

Medical Alert:

Premedication:

Allergies:

DENTAL HISTORY

Does your child have a dental condition about which you are especially concerned? (Yes / No) List Below:

Is this your child's first visit to the dentist? (Yes / No)

Does your child receive dental care on a routine basis? (Yes / No) Date of Last visit: _____

Does your child feel nervous or anxious about having dental treatment? (Yes / No) _____

Has your child had problems with previous dental treatment? (Yes / No) Explain _____

How often are your child's teeth brushed? _____ By whom? _____

Does your child use a manual or electric toothbrush? _____

Is your child receiving fluoride treatments at home or school? (Yes / No) How often? _____

Has your child had orthodontic treatment? (Yes / No) If yes, which office and when: _____

If no, do you feel your child needs orthodontic (tooth straightening) treatment? (Yes / No)

Is your child receiving any speech therapy? (Yes / No) Or had past treatment? (Yes / No) When? _____

Does your child suck his thumb, fingers, or lips? (Yes / No) _____

Is there anything about your child's smile you would like to change or improve? _____

MEDICAL INFORMATION

Medical doctor's Name _____

Address _____ Phone # _____

Is your child currently under the care of a physician? (Yes / No) If Yes, why? _____

Is your child currently taking any medications, prescribed or over-the-counter, including vitamins, supplements and contraceptives? Please List: _____

What is your preferred pharmacy? _____ Phone Number: _____

Is your child allergic to any medications or substances such as latex, codeine, amoxicillin, etc? (Yes / No)

List: _____

Please circle if your child has or had any of the following:

Table with 5 columns listing medical conditions: Abnormal Bleeding, ADD/ADHD, AIDS, Allergies, Anemia, Anxiety, Arthritis/Gout, Artificial Heart Valve, Artificial Joints/Hips, Asthma, Autism, Blood Disease, Blood Transfusion, Bruise Easily, Cancer, Chemotherapy/Radiation, Chest Pain, Cold Sores, Congenital Heart Lesion, Cortisone Medicine, Depression, Diabetes: Type, Drug Addiction, Dry Mouth, Eating Disorder, Emphysema, Epilepsy or Seizures, Excessive Thirst, Fainting or Dizziness, Frequent Cough, Fever Blisters, Glaucoma, Hay Fever, Heart Murmur, Heart Pacemaker, Heart Surgery, Heart Trouble, Hemophilia, Hepatitis, Herpes, High Blood Pressure, Hypoglycemia, Kidney Trouble, Liver Disease, Low Blood Pressure, Lung Disease, Mental Health Disorder, Nervousness, Pain in jaw joints, Parathyroid Disease, Psychiatric Care, Rheumatism, Sickle Cell Anemia, Scarlet Fever, Sinus Trouble, Shortness of breath, Stroke, Swelling of Feet/Ankles, Hands, Thyroid Disease, Tuberculosis, Ulcers, Venereal Disease, X-ray or Cobalt Treatment, Yellow Jaundice.

Have you ever had any other serious illness, condition or surgery not listed above? (Yes / No) If yes, please list with dates: _____

I certify that I have read and understand the above. To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____ Signature of Parent or Guardian

Reviewed by Doctor/RDH _____ Date _____

Date: _____

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MINOR HEALTH HISTORY FORM

Name: _____
Last First Middle

Preferred Name: _____ Male Female Birth date: _____

Brothers and sisters in the family: _____

CONTACT INFORMATION

ADDRESS

TELEPHONE

Home _____

Mother's Cell _____

Father's Cell _____

Other _____

Email: _____

Who should be contacted for this account? _____

Best time to contact parent: AM PM

On the: Home Cell Work

INSURANCE INFORMATION

FATHER'S INFORMATION

Father's Name _____ Date of Birth _____

Address (if different from patient) _____

Employer _____ Work Phone # _____

Dental Insurance Co. _____ Customer Service Phone # _____

SSN or Member ID # _____ Group # _____

MOTHER'S INFORMATION

Mother's Name _____ Date of Birth _____

Address (if different from patient) _____

Employer _____ Work Phone # _____

Dental Insurance Co. _____ Customer Service Phone # _____

SSN or Member ID # _____ Group # _____

REFERRAL TRACKING: HOW DID YOU HEAR ABOUT OUR OFFICE?

Current Patient of ours

Doctor

Other: Please specify

Name _____

Name _____

Drove by and saw office

Phone Book

Internet

EMERGENCY CONTACT

Name (other than parents) _____ Relationship to Patient _____

Home Phone _____ Alternate Phone _____

ACCOUNT PREFERENCES

Who is responsible for paying for this account?

Would your family like to receive your monthly statements by e-mail? Yes No

At Huckabee & Huckabee our office policy is payment at the time of service. If insurance is involved we will expect your estimated percentage. Our office will not be held responsible for inaccurate insurance estimates. We require a 24-hour notice for any appointment change. If 24-hour notice is not received, there will be a cancellation fee added to your account. This charge is not a covered benefit by your insurance company and will be your responsibility. We will not be able to reschedule any dental appointments until the charge is paid. Monthly late charges will be added to any unpaid balance after 60 days at the rate of 18% APR of the unpaid balance. If a personal check for any payment is returned unpaid, you will be charged a returned check fee of \$25.00. If it becomes necessary to turn this account over for professional collection, you will be responsible for their charges as well as your unpaid balance for our services. Should it become necessary to take legal action to collect any unpaid balance, you will be charged for any expenses incurred in connection with such action, including reasonable attorney's fees.

Authorization

I hereby authorize payment directly to Huckabee & Huckabee DDS for group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Huckabee & Huckabee DDS to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on reverse) are correct to the best of my knowledge.

Signature of Responsible Party _____ Date _____

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