ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. _____

Please use an "X" to mark your answers to the following questions.	Yes	No	?	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to childhood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ☐ ADD/ADHD
- ☐ Alcohol/Drugs
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Bone/Joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart Issue
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually transmitted infection (STI)
- ☐ Sickle Cell Anemia
- ☐ Thyroid issues
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Other: _____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?	☐	☐	☐
If yes, please list them here: _____			
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?	☐	☐	☐
If yes, please list those medications and what happened when the patient took them: _____			
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.?	☐	☐	☐
If yes, please describe the allergy and the reaction: _____			

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only:

☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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PATIENT INFORMATION

Date_____ Patients Full Name_____

Address_____City_____State_____Zip_____

Home Phone_____Birthday_____Social Security #_____

If patient is a minor, give parent's or guardian's name_____

How did you find us? ❒ Referral _____ ❒Yellow pages ❒Internet ❒Newspaper

Person to contact in case of Emergency_____Phone #_____

Nearest relative not living with you_____Phone #_____

ACCOUNT INFO
PERSON RESPONSIBLE FOR ACCOUNT

Name_____Relation_____Home#_____

Work #_____Mobile #_____Birthdate_____

Billing Address_____City_____State_____Zip_____

Email_____Employer_____Employer Address_____

_____City_____ State_____Zip_____

INSURANCE INFORMATION

Provider Name_____Provider Address_____

City_____State_____Zip_____Group #_____

Insured's Name_____Relation_____Insured's Birth Date_____

Insured's SSN #_____Insured's Employer_____Insured's Phone #_____

SECONDARY INSURANCE

Provider Name_____Provider Address_____

City_____State_____Zip_____Group #_____

Insured's Name_____Relation_____Insured's Birth Date_____

Insured's SSN #_____Insured's Employer_____Insured's Phone #_____

We require 3 signatures please...

Practice Acknowledgments

Katrina Eglian, D.M.D.

Dental Materials Fact Sheet

I,_____, received and read the Dental Materials Fact Sheet Summary from Dr. Eglian. I am aware that a full disclosure is available at the front desk.

X_____ X_____
Signature Date

Financial Guideline

I fully understand the Financial Guidelines for the office of Katrina Eglian, D.M.D.
I acknowledge that I am responsible for the payment of services regardless of insurance decision.
I understand that payments are due at the time of services, unless otherwise arranged.

X_____ X_____
Signature Date

Acknowledge of Receipt of Notice of Privacy Practices

I,_____, have received a copy of this office's Notice of Privacy Practices. You may refuse to sign this acknowledgment.

X_____ X_____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other

Katrina Eglian, D.M.D.

Family and Cosmetic Dentistry

20921 Walnut Street
Red Bluff, CA 96080
Office (530) 527-7951
Fax (530) 527-7955

NO SHOW POLICY

We would like to take this opportunity to inform you of our NO SHOW POLICY.

An appointment is considered to be a "No-show" if the patient does not come to the scheduled appointment and when the appointment is canceled or rescheduled within two hours of the scheduled appointment.

Our No Show Policy is as follows:

When you schedule an appointment we look forward to being a part of your dental journey, and when you miss an appointment we miss you. We understand that things come up, but it is our mission to make sure your dental needs are met. After a missed appointment we will make every good faith effort to contact you. We may call you directly, leave a phone message, and/or send a letter asking you to contact us.

Please note: If a patient does not come to 3 scheduled visits in a 12 month period, or if a patient has excessive rescheduling or canceling of appointments, the patient may be discharged from our office.

When you sign this paper, you certify that you have read and understand the above information regarding our No Show, Cancellation, and Reschedule Policy, and understand that if you are unable to attend a scheduled appointment or bring your child to a scheduled appointment, it is your responsibility to contact us 24 hours in advance.

NAME OF PATIENT

PATIENTS DATE OF BIRTH

SIGNATURE OF PATIENT / RESPONSIBLE PARTY

DATE

Katrina Eglian, D.M.D.

20921 Walnut Street
Red Bluff, CA 96080
530-527-7951

In compliance with the HIPAA regulations and law, we are not able to speak w/ anyone other than you the patient regarding any medical information. If you have someone that you authorize us to leave information with or speak with regarding your medical care please list them below. Thank you.

1. _____

2. _____

3. _____

4. _____

5. _____

_____ _____

Patient Signature Date