Pediatric Health
History Form

DURHAMDDS

Patient Guardian's Email Address (for appt confirmation):

Todays Date _____

Patient's Name: _____ Sex: M F Age: _____

School Name (if attending): _____ Child's Birthdate: _____

Parent(s) Name: _____ Social Security No: ___ – ___ – _____

Home Address: _____ Home Phone No.: _____

Occupation: _____ Office Phone No..: _____

Place of Employment: _____ City: _____

Spouse's Name (if appl.): _____ Social Security No.: ___ – ___ – _____

Occupation: _____ Office Phone No.: _____

Place of Employment: _____ City: _____

Name of Patient's Physician: _____ Office Phone No.: _____

Physician's Address (if known): _____

Who will be responsible for this account?

Dental Insurance: Y N Name of Insurance Co.: _____ Group No.: _____

Name of Insurance Co.: _____ Group No.: _____

Who may we thank for referring you? _____

In case of emergency, whom should we contact? Name: _____

Relationship: _____ Phone No: _____

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1. Is your child under treatment by a physician? Y N

2. Is your child taking any medicine now? Y N

   If yes, please list: _____

3. Has your child ever been seriously sick or hospitalized? Y N

4. Have you ever been told by your physician that your child has a heart murmur? Y N

5. Does your child have asthma or hay fever (please circle which) Y N

6. Does your child get hives or skin rashes? (please circle) Y N

Turn Over

7. Is your child physically, mentally or emotionally handicapped? Y N

8. Has your child ever experienced an unusual reaction to any of the following medications? (please check if yes)

____ Aspirin ____ Penicillin ____ Local Anesthetic

Other: _____

9. Has your child ever had any history of the following (please check):

____ Rheumatic Fever ____ Heart Trouble ____ Diabetes

____ Rheumatoid Arthritis ____ Jaundice (yellow skin or hepatitis)

____ Tuberculosis ____ Scarlett Fever ____ Epilepsy

____ Bleeding Disorders ____ Measles ____ Convulsions

____ Ear, Eye, Throat Disorders ____ Kidney/Liver Problems ____ Latex Allergy

Other: _____

10. When your child is scratched or cut, has prolonged bleeding been a problem? Y N

11. Is your child receiving fluoride tablets/drops at this time? Y N

12. Is this the first dental visit for your child? Y N

13. Has your child had any difficulty accepting dental or medical treatment previously? Y N

14. Do you anticipate your child having difficulty accepting dental treatment today? Y N

15. Does your child have any of the following habits:

____ Thumb/Finger Sucking ____ Nail Biting ____ Excessive Sugar Intake

____ Lip Biting ____ Nursing Bottle Habits

YES NO (circle) I authorize this office staff to do fluoride treatments or radiographs when warranted and a parent is unavailable to ask permission.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental service my child may need.

Signature of parent/guardian: _____

Relationship to patient: _____

Thank You

DURHAM DDS

PEDIATRIC DENTAL CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for your child's dental treatments. Please read this form carefully and ask about anything you do not understand.

1. I hereby authorize Dr. William Argersinger, assisted by other dental auxiliaries of his choice, to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. The following are procedures a general dentist may perform. Any of the following will be explained prior to the specific procedure.
You have the right to refuse consent to a procedure before it is performed. In general terms the dental procedure(s) or operation may include:

- Cleaning of the teeth and the application of dental fluoride varnish.
- Dental radiographs or "x-rays".
- Application of composite resin "sealants" to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations.
- Removal (extraction) of teeth that are unrestorable or planned for extraction due to severe infection or orthodontic space planning.
- Use of dental anesthesia to accomplish the necessary treatment.

I hereby state that I have read and understand this consent, and that all questions about the procedure or the procedures have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's or legal ward's treatment. I further understand that this consent will remain in effect until such time I choose to terminate it.

Patient's name: _____

Date: _____

Signature of Patient or Guardian: _____

Relationship to Patient: _____

Witness: _____

Dentist's signature: _____