LASKY PEDIATRIC DENTAL GROUP
PATIENT HEALTH HISTORY FORM

Patients full name:_____**Middle Initial:** _____ **Age**:_____**Birthdate**:_____ **Sex**: M F

Parent (Name in full):_____ M F
Residence Address: _____
City: _____ Zip: _____
Residence Phone: (_____)_____
Cell Phone: (_____)_____
E-mail Address: _____
Employed by:_____
Business Phone: (_____)_____
Occupation:_____
*Driver's License Number: _____
SS #: XXX-XX-___ ___ ___ ___ Birthdate: _____

Parent (Name in full): _____ M F
Residence Address:_____
City:_____ Zip:_____
Residence Phone: (_____)_____
Cell Phone: (_____)_____
E-mail Address: _____
Employed by:_____
Business Phone(_____)_____
Occupation:_____
*Driver's License Number: _____
SS #: XXX-XX-___ ___ ___ ___ Birthdate: _____

Patient's Physician: _____ City: _____
*Referred by: _____
Former Dentist: _____ Orthodontist: _____
List children in family who are patients here: _____
Dental Insurance Yes_____ No _____ Carrier: _____
Has your child ever been hospitalized? _____Medications:_____
Has your child ever had/ have/ been diagnosed with any of the following conditions or had an adverse reaction to any of the following? If yes, please check.

___ Allergy- Food Color	**___ Allergy – Latex**	**___ Allergy – Local Anesthetic**
___ Allergy – Penicillin	**___ Allergy – Sulfa Drug**	**___ Allergy – Erythromycin**
___ Anemia – Sickle Cell	**___ Anemia**	**___ Arthritis**
___ Asthma	**___ Behavior – Anxiety**	**___ Behavior – Autism**
___ Behavior – Language Delay	**___ Behavior – OCD**	**___ Behavior - PDD**
___ Behavior – Psych. Care	**___ Behavior – Tourette**	**___ Behavior – ADHD or ADD**
___ Behavior – Depression	**___ Bleeding Disorder**	**___ Blood Disease**
___ Cancer	**___ Celiac Disease**	**___ Cerebral Palsy**
___ Chemo Treatment	**___ Cleft Lip or Palate**	**___ Crohns / Colitis**
___ Cystic Fibrosis	**___ Diabetes Type 1**	**___ Diabetes Type 2**
___ Dialysis	**___ Down Syndrome**	**___ Epilepsy**
___ Febrile Seizures	**___ Hearing Disability**	**___ Heart Condition**
___ Heart Murmur – Premed	**___ Heart Murmur – Benign**	**___ Hepatitis A**
___ Hepatitis B	**___ Hepatitis C**	**___ HIV**
___ Kidney Disease	**___ Liver Disease**	**___ Mouth Ulcers**
___ Prosthetic – Joint(s)	**___ Prosthetic – Limb(s)**	**___ Prosthetic – Other**
___ Radiation Treatment	**___ Respiratory Problems**	**___ Rheumatic Fever**
___ Sensitive to Light	**___ Sensitive to Noises**	**___ Sensitive to Touch**
___ Stomach Problems	**___ Stroke**	**___ Surgery – Adenoids**
___ Surgery – Ear Tubes	**___ Surgery – Heart**	**___ Surgery - Other**
___ Surgery – Tonsils	**___ TB "+" Skin Test**	**___ TB**

___ Unlisted please specify: _____

Medical Consent:
To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medications, I will inform the dentist at the next appointment. My signature below is my consent for treatment of the above mentioned child.

Insurance Authorization:
I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims. I authorize and direct payment of the dental benefits otherwise payable to me, directly to Lasky Pediatric Dental Group.

Insurance Policy:
We will be happy to bill your dental insurance company for treatment completed, but please remember that YOU are responsible for any balance your insurance company does not pay. We are not an HMO or PPO insurance contracted office, and are considered "OUT OF NETWORK".

Financial Responsibility:
The parent or guardian of the child who sets up the account will be considered head of household and financially responsible for payment of treatment rendered.

Financial Policy:
The policy of this office limits accounts to 30 days (insurance and terms excepted) without a late payment charge of 1.5% or 18% APR.

Appointment Policy:
We reserve the right to charge for appointments cancelled or broken without a 24 hour notice.

Signature _____ Relationship _____ Date: _____