Online Patient Health History Form

Submit Your Health History Form Online

Save time at the doctor's office and fill out your registration and health history information online! Take a few minutes to fill out this confidential form, click the "Submit Form" button at the bottom, and your information will be sent to our office with secure encryption. We will already have your information when you arrive for your first appointment. You will need to provide a signature at the office to verify that the information you submitted online is accurate.

This website is compliant with the Health Insurance Portability and Accountability Act (HIPAA). All of your personal health information is confidential, and will not be shared with anyone, aside from those involved in your treatment, without your consent.

Patient Information

First Name

Middle Name

Last Name

Nickname

Home Phone

Birth date (MM-DD-YYYY)

Gender

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

Whom may we thank for referring you to our office?

Other family members seen by us

Responsible Party Information

Full Name

Residence

Street

City

State

Zip

Mailing Address (if different)

Street

City

State

Zip

Home Phone

Work Phone

Cell

Email Address

Birth date

Relationship to Patient

Employer

Occupation

Spouse's Name

Relationship to Patient

Employer

Occupation

Birth date

Home Phone

Work Phone

Cell

Email Address

Dental Insurance Information

Insured's Name

Insured's Social Security Number (U.S. only)

Insurance Company

Group Number

Subscriber ID Number

Insurance Company Address

Street

City

State

Zip

Country

Phone Number

Do you have dual coverage?

Insured's Name

Insured's Social Security Number (U.S. only)

Insurance Company

Group Number

Local Number

Insurance Company Address

Street

City

State

Zip

Country

Phone Number

Emergency Information

Name of the nearest relative not living with you

Complete Address

Street

City

State

Zip

Phone

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment your child receives from our office. This information is kept strictly confidential.

Physician

Date of Last Visit

Address

Street

City

State

Zip

Country

Phone

Please check any of the following which apply to your child, and add any relevant comments.

Are you taking any medication?

Comment:

Are you allergic to any medication or food?

Comment:

Do you have a history of any major illness?

Comment:

Have you had any major operations?

Comment:

Have you ever been involved in a serious accident?

Comment:

Please check any of the following that your child has had or currently has:

Abnormal bleeding/Hemophilia

Anemia

Arthritis

Asthma or Hay fever

Bone Disorders

Congenital Heart Defect

Diabetes

Dizziness

Epilepsy

Gastrointestinal Disorders

Heart Problems

Heart Murmur

Hepatitis/Liver Problems

Herpes

High Blood Pressure

HIV/Aids

Kidney Problems

Pneumonia

Nervous Disorders

Prolonged Bleeding

Radiation/Chemotherapy

Rheumatic Fever

Tuberculosis

Tumor or Cancer

Allergy

Autism

Brain Injury

Bronchitis

Cancer

Cerebral Palsy

Chicken Pox

Cleft Lip/Palate

Convulsions/Seizure

Diphtheria

Drug or Alcohol Abuse

Eye Problems

Hearing Loss

Jaundice

Leukemia

Measles

Intellectual Disability

Mumps

Mouth Breathing

Nutritional Deficiency

Orthopedic Problems

Pneumonia

Polio

Pregnancy

Psychiatric Disorder

Scarlet Fever

Scoliosis

Sickle Cell Anemia

Sinus Problems

Snoring at Night

Sore Throats – Frequent

Spina Bifida

Syndrome _____

Tetanus

Venereal Disease

Whooping Cough

Dental History

What concerns you most about your childs teeth?

Have there been any injuries to face, mouth or teeth?

Comment:

Has your child ever received anesthesia or sedation?

Comment:

Is your child allergic to anything? (medicine, food)

If yes, what?

Does your child smoke or use tobacco products?

Does your child have any behavorial or developmental problems?

If yes, what?

Is this your child's first visit to the dentist?

If not, name the previous dentist

How long ago?

Was dental treatment completed?

Were any of the dental visits unhappy?

Reason for leaving?

What is your primary reason for seeking dental care?

Has your child complained of any dental problems?

Has your child ever had any of the following?

Dental Cavities

Abcesses (gum boils)

Stained teeth

Toothaches

Cold Sores (fever blisters)

Bad Breath

Does (or did) your child have habits which might affect oral health?

Clenching or grinding teeth

Finger or thumb habits

Mouth breathing

Other

Does your child brush daily?

Do you assist?

Is dental floss used?

Do you drink city water, well water, or bottled water?

How would you describe your child's eating and snack habits?

What is your child's attitude towards today's visit?

Does your child have problems in concentraing, learning, cooperating and/or understand?

Is there anything else that you think we should know about your child?

I understand that balances remaining over 60 days from the date of service will be subject to a late fee of $10 monthly, and I agree to pay any and all collection or legal costs incurred should this account be deemed uncollectible. Please remember that insurance is considered a benefit and a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to know your policy and to pay any deductible amount, percentage or other balances not paid for by your insurance company at the time of services unless other arrangements have been made. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

To be filled out in office*

Signature _____ Date _____*