CHILD HEALTH HISTORY

8340 Cleveland Ave NW
North Canton, OH 44720
330-494-6305
www.NorthCantonSmiles.com

Child's Name:________________________________Nickname:_________________________
First Middle Last

Sex: M____ F_____ Birth date:_____________ Age:____ Reason for visit?__________________

Is this your child's first dental visit?__________ Date of last dental visit?______________________

What is your child's attitude toward previous dental care?__________________________________

Have we seen other children in your family?_______ Names_______________________________

Whom may we thank for referring you to our office?_____________________________________

Is your child adopted?__________

MEDICAL INFORMATION

Is your child under a physician's care now?______ For what reason?_________________________

Physician's name___________________________________ Ph #:______________________

Is your child on medication or drugs?__________ What kind?______________________________
Reason?____

Has your child ever been hospitalized?__________ When?____________
Reason?____

Has your child had a history or difficulty with any of the following?

Premature Birth	Yes No	Anemia	Yes No
Brain Injury	Yes No	Speech Disorder	Yes No
Heart	Yes No	Diabetes	Yes No
Cancer or Malignancies	Yes No	Hepatitis	Yes No
Bone Disorder	Yes No	Allergies to Medication	Yes No
Rheumatic Fever	Yes No	Seizures	Yes No
Kidneys	Yes No	AIDS	Yes No
Bleeding	Yes No	Asthma	Yes No
Cerebral Palsy	Yes No	Liver	Yes No

Hearing Yes No Earaches Yes No

Gag Reflex Yes No

Comments / details____

Does your child have any emotional or school problems?________________________________

DENTAL INFORMATION

Was your child bottle fed? Yes No Until what age?_______

Breast fed? Yes No Until what age?_______

Does your child have any mouth habits, finger/ thumb sucking _____ pacifier_______ other _______

Has your child ever had any injuries to his teeth, mouth or head?______ When?______
Details?____

Does your child brush regularly? Yes No Does an adult assist with brushing? Yes No

Does your child floss? Yes No Does an adult assist with flossing? Yes No

Have either parent or child been treated orthodontically? Yes No

Who has received treatment?____

How would you expect your child to behave in our office?_________________________________

Describe your child: Outgoing____ Shy____ Stubborn____ Anxious____ Frightened____

How may we help to make this visit a positive experience for your child?______________________

GENERAL INFORMATION

This information is requested for financial and credit purposes.

FATHER(full name)____

Address________________________________ City___________________State______ Zip______

Best Ph #___________ SS#_____-______-______ Birth date____________ Marital Status:_______

Employer__________________________ Work Ph #_______________ Cell Ph #_______________

Address________________________________ City___________________State______ Zip______

Email Address______________________@_______________ Driver License #_________________

MOTHER(full name)____

Address________________________________ City___________________State______ Zip______

Best Ph #____________ SS#_____-______-______ Birth date_____________ Marital Status:________

Employer____________________________ Work Ph #________________ Cell Ph #________________

Address___________________________________ City____________________State______ Zip______

Email Address________________________@________________ Driver License #__________________

Name of nearest relative_______________________ Home Ph #__________ Work Ph #___________

Relation to which parent and relation to patient____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of subscriber___________________________Subscribers ID_____________ Grp. No.__________

Name of Insurance Co. ____ Ph #___________________

Address___________________________________ City____________________State______ Zip______

Policy holders employer____

SECONDARY DENTAL INSURANCE

Name of subscriber___________________________Subscribers ID_____________ Grp. No.__________

Name of Insurance Co. ____ Ph #___________________

Address___________________________________ City____________________State______ Zip______

Policy holders employer____

Assignment of Benefits: I authorize Dr. Bertolini to furnish my insurance company with all the information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Dr. Bertolini. I understand I am responsible for charges not covered by this assignment.

Our financial policy is to receive payment in full by the time treatment is completed. If this is not convenient for you, we do accept VISA, Discover , Mastercard and can direct you to other sources of credit. If you have dental insurance, we will submit your claim and you will be billed for any remaining balance not paid by your insurance company.

SIGNATURE:____DATE:________________

Signature/ Guardian (if under 18 years old)