***Ages 13-17***

# Youth Health History

## *Section 1 – Patient's Information*

**Patient's Name**: ________________________________________________ Today's Date: ___/___/___
LAST FIRST MI

What patient prefers to be called:_________________________________ ☐ Male ☐ Female

Birthdate: _____/_____/_______ Age: _____ SS#: __________________________________

Mailing Address: ______________________________________________________________

____________________________________________________________ Home Phone #: (____)________________
CITY STATE ZIP

School: __________________________________________ Grade: ______ Hobbies: ________________________________________

## *Section 2 – Parent's Information*

Parent's Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

☐ **Father** ☐ **Step Father** ☐ **Guardian**

Name: ___________________________________________ Birthdate: ____/____/_______ SS#: _________________________

Mailing Address (if different than child's): _____________________________________________________________________

____________________________________________________________ DL# ________________________________________
CITY STATE ZIP

Home Phone #: (____)__________________ Work Phone #: (____)______________________ Ext.: _______

Cell Phone #: (____)_____________________ Email: ______________________________________________

Employer: ____________________________________________ Occupation: _____________________________

Employer's Address: ___________________________________________________________________________

____________________________________________________________
CITY STATE ZIP

**If you have dental insurance for the child please fill out below:**

Company Name: ____________________________________________________

Address: ____________________________________________________________

____________________________________________________________ Phone #: (____)_______________________
CITY STATE ZIP

Insured's SS#: _______________________________ Group # (Plan, Local or Policy #): _______________________

☐ **Mother** ☐ **Step Mother** ☐ **Guardian**

Name: ___________________________________________ Birthdate: ____/____/_______ SS#: _________________________

Mailing Address (if different than child's): _____________________________________________________________________

____________________________________________________________ DL# ________________________________________
CITY STATE ZIP

Home Phone #: (____)__________________ Work Phone #: (____)______________________ Ext.: _______

Cell Phone #: (____)_____________________ Email: ______________________________________________

Employer: ____________________________________________ Occupation: _____________________________

Employer's Address: ___________________________________________________________________________

____________________________________________________________
CITY STATE ZIP

**If you have dental insurance for the child please fill out below:**

Company Name: ____________________________________________________

Address: ____________________________________________________________

____________________________________________________________ Phone #: (____)_______________________
CITY STATE ZIP

Insured's SS#: _______________________________ Group # (Plan, Local or Policy #): _______________________

## *Section 3 – Release*

I certify that my child is covered by ____________________________Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_______________________________________________________
Signature of Parent or Guardian Date

## *Section 4 – General Information*

Who is accompanying the child today? ________________________________ Relation: ________________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? ____________________________________________

Other siblings: ______________________________________________________________

**Previous Dentist (if applicable)** ____________________________ (____)____________________

NAME PHONE #

Last Dental exam: ____/____/____ Last Dental X-rays: ____/_____/_____

Relative or friend not living with you:

Name: ___________________________Phone: (____)___________________

Address: _____________________________________________

_____________________________________________________

CITY STATE ZIP

## *Section 5 – Dental & Medical History*

Why did you bring your child to the dentist today? _________________________________________

Is the child currently in pain? ☐ Yes ☐ No Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: ______________________ Phone #: (______)_______________ Date of Last Visit: ___/___/___

Is the child currently under the care of a physician? ☐Yes ☐No

Please describe the child's current physical health: ☐Good ☐ Fair ☐Poor

**Please list all drugs that the child is currently taking:** ____________________________________________

**Please list all drugs/things the child is allergic to**: ____________________________________________

**Has the child experienced any of the following medical problems? (circle yes (Y) or no (N))**

| Y | N | Condition | Y | N | Condition | Y | N | Condition | Y | N | Condition |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Y | N | Anemia | Y | N | Any Hospital Stays/Operations? | Y | N | Chicken Pox | Y | N | Abnormal Bleeding |
| Y | N | Cancer | Y | N | Artificial Bones/Joints/Valves | Y | N | AIDS/HIV+ | Y | N | Heart Murmur |
| Y | N | Diabetes | Y | N | Handicaps/Disabilities | Y | N | Convulsions | Y | N | Rheumatic Fever |
| Y | N | Asthma | Y | N | Congenital Heart Defect | Y | N | Liver Problems | Y | N | Low Blood Pressure |
| Y | N | Hives | Y | N | Exposed to HIV, but Neg. | Y | N | Mononucleosis | Y | N | Kidney Problems |
| Y | N | Measles | Y | N | Hearing Impairment | Y | N | Skin Rash | Y | N | Scarlet Fever |
| Y | N | Epilepsy | Y | N | High Blood Pressure | Y | N | Hemophilia | Y | N | Prosthetics |
| Y | N | Hepatitis | Y | N | Mitral Valve Prolapse | Y | N | ADD/ADHD | Y | N | Tuberculosis (TB) |

Are the child's immunizations current? ☐ Yes ☐ No Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences(ed): ______________________________

I affirm that the information I have given is correct to the best of my knowledge. 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 authorize the dental staff to perform the necessary dental services as my child may need.

_____________________________________________ _____/_____/_____

Signature of Parent or Guardian Date

**Welcome to Mondale Dental!**

**Office Use Only**

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_______________________________ ____/____/____

Signature of Dentist Date

Dentist's Comments: ______________________________

__________________________________________

__________________________________________

**Medical History Update**

Has there been any change in your child's health status since their last visit?

__________________________________________________

_____________________ ___/___/____ __________________ ___/___/___

Parent/Guardian Signature Date Dentist Signature Date

Has there been any change in your child's health status since their last visit?

__________________________________________________

_____________________ ___/___/____ __________________ ___/___/___

Parent/Guardian Signature Date Dentist Signature Date