

Mount Auburn Dental

Youth Health History 2020



Thank you for providing us with the necessary confidential information which will help us to know your child/young adult and make his/her visits with us more enjoyable.

Child's Name: _____ Date of Birth: _____ Sex: M F
Primary Address: _____ Phone: _____ Cell: _____
Is this their first visit to the dentist? Y N Former Dental Office: _____

Parent/Guardian Information

Adult responsible for charges: _____
Mother's Name: _____ Home Phone: _____ Cell: _____
Father's Name: _____ Home Phone: _____ Cell: _____
Child lives with: ___ Both ___ Mom ___ Dad ___ Other: _____ Tele: _____

Dental Insurance: _____ Subscriber: _____
Subscriber Date of Birth: _____ Employer: _____
Subscriber ID: _____ **Group#:** _____

Please give your insurance card at the front desk to copy for our records.

We are happy to submit your dental claims to your insurance and will do everything we can to see that you receive the benefits you are entitled to however, this is YOUR insurance. If your insurance company has not paid on your claim within 45 days, the FULL balance will automatically be transferred to you. You are responsible to seeing that we have your current dental insurance on file. Thank you.

Is your child in good health? Y N- explain _____
Name of your child's pediatrician/Dr: _____ Phone: _____
Pharmacy: _____ Where: _____

Habits

Does your child have any of these habits:
___ thumb/finger sucking ___ Mouth Breathing ___ Tongue Thrust ___ Clenching or grinding ___ Nail Biting
___ Other _____

Your child's overall health, as well as any medications (prescription OR over-the-counter) could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Is your child allergic to any of the following: Please CIRCLE any that apply.

Aspirin Penicillin/Amoxicillin Codeine Latex Local Anesthetics
Other: _____

Have you ever been told your child needs to be pre-medicated before a dental visit? ___ Y ___ N

Turn the page over to complete

List ALL medications including over-the-counter medication that your child is currently taking:

Please check all that apply to your child currently OR in the past:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis or joint disease | <input type="checkbox"/> Liver Problems, Jaundice | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia or Blood Disorders | <input type="checkbox"/> Psychological or Emotional Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Accidents or Severe Infections | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Latex Allergies |
| <input type="checkbox"/> Dental Phobia | <input type="checkbox"/> Glandular or Hormonal Problems | <input type="checkbox"/> Sensitive Gag Reflex |
| <input type="checkbox"/> Epilepsy, Seizure, or Fainting issues | <input type="checkbox"/> Any pending or recent surgery: _____ | |

Does your child brush his/her own teeth? ☐ Y ☐ N Do you assist your child in brushing? ☐ Y ☐ N
Is your home water supply Fluoridated? ☐ Y ☐ N Is your child's toothpaste fluoridated: ☐ Y ☐ N
Does your child use a fluoride supplement? ☐ Y ☐ N Dose: ☐ 0.25mg ☐ 0.50mg ☐ 1.00mg
Do you give your child any other form of fluoride? What: _____ Amount: _____

Consent for Dental Treatment

I request and authorize Dr. James Helmkamp and his staff to examine, clean and provide my child with comprehensive dental treatment. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Helmkamp to diagnose and/or treat my child's dental condition. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Helmkamp will provide an environment likely to help children/young adults learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I agree that I will remain on site during my child's dental appointment.

I hereby certify that the information supplied is correct and true. I understand that I will be responsible for any and all charges incurred by my child for dental treatment.

Signature

Date

Thank you for entrusting your child's dental care to us. We will do our best to see that your child is comfortable and acquires the knowledge she/he will need to help them to keep their teeth for the remainder of their lives. Through discussions of making better choices for their dental health and great dental care, along with your support we can give them a smile to last a life time!

Please use this space for any addition information that you think we should be made aware:
