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:

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

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/or Dr. Tyler Gagnon, 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 and/or Dr. Gagnon 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 and Dr. Gagnon 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:

_____

_____

_____

_____