# Welcome

**Dr. Maria Isabel Galant**
**227 N Hammes Ave.**
**Joliet, Illinois 60435**
**Phone: 815-729-9991**

## Health History Form

**Today's Date: _____**

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

### 1. Tell Us About Your Child

Child's Name _____
Last First MI
Goes by: _____ ☐ Male ☐ Female
Siblings that we treat _____
Child's Birthdate _____/_____/_____ Child's Age _____
School_____Grade_____
Child's Home # (_____)_____
SS#_____
Child's Home Address:_____
_____
City State Zip
Email Address:_____

### 2. Who may we thank for referring you to our office?

_____

### 3. Mother's Information

Name _____
Mother Stepmother Guardian Birthdate _____/_____/_____
Occupation_____
Employer _____
Business Address _____
Work # (_____)_____ Ext. _____
Home # (_____)_____
Cellular Phone # (_____)_____
Leave voice message: ☐ Cell ☐ Work ☐ Home
SS # _____ DL# _____

### 4. Father's Information

Name _____
Father Stepfather Guardian Birthdate _____/_____/_____
Employer _____
Business Address _____
Work # (_____)_____ Ext. _____
Home # (_____)_____
Cellular Phone # (_____)_____
Leave voice message: ☐ Cell ☐ Work ☐ Home
SS # _____ DL# _____

In case of emergency, if the parents cannot be reached, whom not listed above should we contact.
Name:_____ Relationship: _____
Address:_____ Phone: _____

### 5. Who is Accompanying the Child Today?

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

### 6. Person Responsible for Account

Name_____
Relationship_____
Billing Address _____
_____
City State Zip
Home # (_____)_____
Work # (_____)_____
Cellular # (_____)_____
E-mail _____

### 7. Primary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (_____)_____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

### 8. Secondary Dental Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # (_____)_____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

## 9. Dental History

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

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

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

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting  Y N Nail Biting

Y N Nursing / Bottle Habits  Y N Thumb / Finger Sucking

Y N Grinding of teeth

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

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

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

Frequent Headaches? Yes No

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

Floss his / her teeth daily? Yes No

Do you help with brushing & flossing? Yes No

## 10 Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis

Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes

Please discuss any serious medical conditions the child has had

_____

_____

Hospitalization since birth? Date _____

Reason: _____

Any emergency room visits? Date _____

Reason: _____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____)_____

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

Please describe the child's current physical health...

**Good** **Fair** **Poor**

Developmental problems? Yes No

Behaviour problems? Yes No

***Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.***

## 11

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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 my child may need.

_____ _____ _____

Signature of Parent or Guardian  Date  Relationship to Patient

## For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____