Fieldcrest Dental, PC

Child Patient Health History

How did you hear about us?

_____

Name or source

Patient Name: _____

Last **First** **Middle**

Address: _____

House number & PO Box if applicable **City** **State** **Zip Code**

Home Phone: (_____) _____ Work Phone: (_____) _____

Date of Birth: _____ Male / Female (circle one)

Do you have Dental Insurance? Yes / No
If so, Name of Insurance Company: _____Member ID #:_____

Father's Information

Father's Name: _____

Last **First** **Middle**

Date of Birth: _____ Social Security Number: _____

Employer: _____ Position: _____

Business name **City & State**

Name of Dental Insurance Company: _____

Policy/Group number: _____ Member ID number: _____

Mother's Information

Mother's Name: _____

Last **First** **Middle**

Date of Birth: _____ Social Security Number: _____

Employer: _____ Position: _____

Business name **City & State**

Name of Dental Insurance Company: _____

Policy/Group number: _____ Member ID number: _____

Who is responsible for this account: _____

Emergency contact Person: _____

Name **Relationship** **Phone#**

List All Medications You Are Currently Taking:

_____

_____

_____

Any Medicines You Are Supposed To Be Taking, But Aren't? _____

List All Previous Surgeries with Dates:

_____

_____

Is your General Health Good? Yes / No (if no, why) _____

Currently under Doctors Care? Yes / No (if so, why) _____

Physician's Name _____ Phone # _____

Name **City & State**

Are you allergic to any of the following?

Penicillin *Yes/No* **Codeine** *Yes/No* **Acrylic** *Yes/No* **Metal** *Yes/No* **Latex** *Yes/No*

Sulfa Drugs *Yes/No* **Other:** _____

Please list any dental/oral concerns _____

Please circle any of the following conditions that you have currently or have had in the past:

Cardiovascular
Angina/Chest Pain
Congenital Heart Problems
Heart Attack / Failure
High / Low Blood Pressure
Heart Surgery / Artificial Valve
High Cholesterol
Infective Endocarditis
Irregular Rhythm / Pacemaker
Murmur

Respiratory
Asthma
COPD
Easily Winded
Emphysema
Frequent Sinus Trouble
Other Breathing Problems
Tuberculosis

Neural / Neurovascular / Psych

Liver/Kidney/Gastro-Intestinal
GERD (Acid Reflux)
Hepatitis
Kidney Problems
Liver Disease (Other)
Ulcers

Musculoskeletal
Arthritis / Gout
Artificial Joint

Rheumatic Fever

Blood
Anemia
Hemophilia

HIV / AIDS
Bruise Easily / Thin Blood
Organ Transplant (Received or Donor)

Alzheimer's / Dementia
Anxiety / Depression
Epilepsy / Seizures
Fainting / Dizzy Spells
Glaucoma

Neuralgia
Psychiatric Care (Other) _____
Stroke

Bone / Muscle Other _____
Osteoporosis

Cancer
Cancer (Type) _____

Chemotherapy
Radiation Therapy

Please be sure to read, sign and date of all the bottom approvals.
Patient, Parent or Guardian:

This information has been answered to the best of my knowledge, and I will update Dr Hamper, DMD and their staff of any medical changes in the future. My signature authorizes the release of information to my insurance company and it authorizes assignment of benefits when applicable.

Signature: _____ Date: _____

Patient, Parent or Guardian:

I hereby agree to the following terms and conditions:

There is a 1.5% monthly late charge assessed on all balances after 90 days past due. Checks, which are declared non-sufficient funds, will be charged a $30.00 service fee. Also, the undersigned agrees to pay collections fee of 33% of the total owed when sent to collections. All attorney fees and court costs incurred by the creditor. All the information provided is correct.

I have read and understand the above paragraph in its entirety.

Signature: _____ Date: _____

Patient, Parent or Guardian:

NOTICE OF PRIVACY PRACTICE

I have received a Notice of Privacy Practice

Patient name (print) _____

Signature: _____ Date: _____

Patient unable or refused to sign acknowledgement3.96