# Henry Delclos, DDS, PC

*DENTISTRY FOR CHILDREN*

We welcome your child into our practice and we will try to make his or her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in aiding us to better understand your child.

Child's Name_____Sex: _____ M or F

What is your child called (nickname)? _____ Social Security # _____

Attends what school _____ Grade _____ Date of Birth _____ Weight _____

Name and age of brothers and sisters _____

Child's physician or pediatrician _____

Physician's phone _____ Family Dentist _____

Dental Insurance: Yes _____ No _____

Name of Insurance company _____

Who may we thank for referring you to our office? _____

Address if known _____

Purpose of this visit _____

Name and kind of child's pet, toy, hobby, or sport activity _____

| **HEALTH HISTORY** | **yes** | **no** |
|---|---|---|
| Is child under care of a physician now? | _____ | _____ |
| Is child receiving any medication or drugs? | _____ | _____ |
| Is there any excessive bleeding when cut? | _____ | _____ |
| Has child ever been hospitalized? | _____ | _____ |
| Has child ever had surgery? | _____ | _____ |
| Is there any allergy to penicillin or other drugs? Drug reactions? | _____ | _____ |
| Are there other allergies: food –pollen -animals –dust –other? | _____ | _____ |
| Does your child have good physical coordination? | _____ | _____ |
| Are there any emotional problems? | _____ | _____ |
| Has your child ever had any lower facial trauma or trauma to the mouth? | _____ | _____ |

Any other information that I should be aware of that we have not discussed? Please describe _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

| | | | | |
|---|---|---|---|---|
| ___Anemia | ___Chronic Sinus | ___Hearing | ___Jaw Joint-TMJ | ___Rheumatic Fever |
| ___Asthma | ___Convulsions | ___Heart | ___Measles | ___Thyroid |
| ___Bladder | ___Diabetes | ___Kidney | ___Mononucleosis | ___Tuberculosis |
| ___Cerebral Palsy | ___Epilepsy | ___Liver | ___High Temperature | ___Blood Products |
| ___Chicken Pox | ___Fainting | ___Malignancies | ___Pregnancy | ___Frequent Headaches |
| ___Hepatitis | ___AIDS (HIV) | ___Blood Transfusions | ___Other | ___Head/Neck Injury |

**DENTAL AND FAMILY HISTORY** **yes** **no**

1. Has your child any history of thumbsucking, fingersucking, or did he use a pacifier past age 1 ½ years? _____ _____
   (underline condition)

   Is this a currently active habit? _____ _____

2. Is your child still feeding on the bottle or breast? If no, at what age did this stop? _____ _____ _____

3. Has your child had his or her tonsils and/or adenoids removed? _____ _____

4. Does your child have or has he/she had in the past, frequent ear and throat infections, is, or tubes in ears?_____ _____

5. Has your child any history of hearing loss or speech problem? _____ _____

   (underline and explain) _____

6. Is your child adopted? _____ _____

7. Has mother or father had a lot of tooth decay? _____ _____

8. In your family is there any history of malocclusions, bad bites, missing or extra teeth? _____ _____

9. Has your child ever had a space maintainer, retainer, braces, orthodontics treatment, or dental tooth movement? Explain _____ _____ _____

10. Was your child early, average, or late at getting his baby and/or permanent tooth? (underline)

11. Has your child had any unfavorable experience in a dental or medical office? _____ _____
    (underline and explain) _____

12. Do you consider your child to be high strung or generally nervous or hyperactive? _____ _____

13. How does your child react to an injury? _____

14. How does your child behave around strangers? _____

15. Has your child had a toothache recently? _____ _____

16. Is your child in pain now? _____ _____

17. Has your child had previous dental treatment? _____ _____
    When and where _____

| | yes | no |
|---|---|---|
| 18. Do mother and father of child live together? If no, please explain _____ | _____ | _____ |
| 19. Do you use bottled or highly filtered water? Reverse Osmosis? | _____ | _____ |

Remarks

_____

_____

_____

Texas DL# _____ Texas DL# _____

Father _____ Mother _____
Full Name Full Name

DOB _____ DOB _____

Social Security # _____ Social Security # _____

Father's Home Address _____ Phone _____
Street City State Zip Code

Father Employed _____ Cell # _____
If self, state business name

Occupation _____

Business address _____ Phone _____
Street City State Zip Code

Mother's Home Address _____ Phone _____
Street City State Zip Code

Mother Employed _____ Cell # _____
If self, state business name

Occupation _____

Business address _____ Phone _____
Street City State Zip Code

In case of emergency – Name of nearest relative or friend _____

Phone _____ Relation _____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and /or all necessary dental treatment is performed.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. I understand that responsibility for dental services provided in this office for my child are mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. Dr. Delclos will submit my insurance as a courtesy to me; however, regardless of what the insurance pays, I am ultimately responsible for my account balance.

I authorize your office to release information to my insurance company or any insurance company for claims processing. This consent and authorization includes the use of any photographs, models, x-rays, of any part of my oral and adjacent structures for records, teaching, research, clinical or scientific study or publication with suitable anonymity.

Signed _____ Date _____

## INSURANCE INFORMATION

Name of Patient _____

**PRIMARY INSURANCE INFORMATION**

Insured Employee _____

Social Security Number _____ DOB _____

Employer _____

Insurance Company _____

Phone Number _____(to verify coverage)

Address _____

Group or Policy Number _____

**SECONDARY INSURANCE INFORMATION**

Insured Employee _____

Social Security Number _____ DOB _____

Employer _____

Insurance Company _____

Phone Number _____(to verify coverage)

Address _____

Group or Policy Number _____