Geoffrey A. Groat, D.D.S., Inc.
Christopher A. Groat, D.D.S., Inc.

Pediatric Dentistry

1350 West Seventh Street • San Pedro, CA 90732 • (310) 832-5133

Health History Form

COMPLETE ALL INFORMATION AND BRING IT WITH YOU ON YOUR FIRST VISIT TO OUR OFFICE. 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)

Nickname _____ ○ Male ○ Female

Siblings that we treat _____

Child's Birthdate ___/___/___ Child's Age _____

Child's Home # ( ) _____

SS# _____

Child's Home Address: _____

_____ APT./CONDO #

_____ City / State / Zip

School _____ Grade _____

2. Who Is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? ○ Yes ○ No

3. Person Responsible For Account

Name _____

Relationship _____

Billing Address _____

_____ City / State / Zip

Home # ( ) _____

Work # ( ) _____

E-Mail _____

4. Mother's Information

Name _____

○ Stepmother ○ Guardian Birthdate ___/___/___

Home Address: _____

_____ APT./CONDO #

_____ City / State / Zip

Employer _____

Occupation _____

Work# ( ) _____ Ext. _____

Home# ( ) _____

Cellular Phone # ( ) _____

SS # _____ DL # _____

Marital Status ○ Single ○ Married ○ Separated ○ Widowed ○ Divorced

5. Father's Information

Name _____

○ Stepfather ○ Guardian Birthdate ___/___/___

Home Address: _____

_____ APT./CONDO #

_____ City / State / Zip

Employer _____

Occupation _____

Work # ( ) _____ Ext. _____

Home # ( ) _____

Cellular Phone # ( ) _____

SS # _____ DL # _____

Marital Status ○ Single ○ Married ○ Separated ○ Widowed ○ Divorced

6. Dental History

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

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

Name of previous dentist _____

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

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

If yes, please explain _____

_____

_____

Age at time of injury _____

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

_____

_____

Does the child have any of the following habits?

Y N Nursing Bottle Habits Y N Thumb / Finger Sucking

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

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

Floss his / her teeth daily? Yes No

7. Health History

Has the child ever had any of the following problems?

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 Heart Disease
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Brain Injury

Please discuss any serious medical problems the child has had

_____

_____

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

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

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

8. 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_____

Address _____

Phone # ( )_____

9. 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 _____

Address _____

Phone # ( )_____

10. 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 HEREBY AUTHORIZE DR. GEOFFREY GROAT AND/OR HIS ASSOCIATES TO PERFORM ANY AND ALL TREATMENT FOR MY ABOVE NAMED CHILD AND CONSENT TO SUCH METHOD, DRUGS, AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED.

Signature _____ Relationship to child _____ Date _____

PLEASE NOTE: Payment is expected for service rendered at time of visit. A 1 $^{1}/_{2}$ percent monthly finance charge is added to all amounts after 60 days. (Annual rate of 18%)