SUMMERLIN
pediatric dentistry

HEALTH HISTORY UPDATE
PLEASE COMPLETE ALL AREAS

Phone: 702-838-9013
Fax: 702-838-9157

Child's Name: _____ Child's Date of Birth: ____/____/____ [ ] male [ ] female

Address: _____ City, State, Zip: _____

DO PARENTS RESIDE AT SAME ADDRESS? [ ]YES [ ] NO IF NO, PLEASE PROVIDE BOTH ADDRESSES:

PLEASE CIRCLE:
Mother, Father, Legal Guardian: Name: _____ Date of Birth: ____/____/____

Address: _____ City, State, Zip: _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

SSN: ____-____-____ Email address: _____

PLEASE CIRCLE: +
Mother, Father, Legal Guardian: Name: _____ Date of Birth: ____/____/____

Address: _____ City, State, Zip: _____

Home ( ) _____ Work ( ) _____ Cell ( ) _____

SSN: ____-____-____ Email address: _____

Who would you like the primary contact to be? _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

***Prime* Insurance Info**: [ ] mom [ ] dad [ ] stepparent [ ] legal guardian

Employer: _____

Name of Dental Ins: _____

Phone #: _____ Group/policy # _____

Member Id: _____

***Secondary* Insurance Info**: [ ] mom [ ] dad [ ] stepparent [ ] legal guardian

Employer: _____

Name of Dental Ins: _____

Phone #: _____ Group/policy # _____

Member Id: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING MEDICAL ISSUES? :

1 Cardiac History	[ ]yes [ ]no	13 Vision Impairment	[ ]yes [ ]no	25 Latex Allergy	[ ]yes [ ]no
2 Rheumatic Fever	[ ]yes [ ]no	14 Asthma	[ ]yes [ ]no	26 Metal Allergy	[ ]yes [ ]no
3 Blood/Bleeding Disorder	[ ]yes [ ]no	15 Wheezing	[ ]yes [ ]no	27 Hepatitis	[ ]yes [ ]no
4 Birth/Genetic Disorder	[ ]yes [ ]no	16 Eating Disorder	[ ]yes [ ]no	28 ADHD/OCD	[ ]yes [ ]no
5 Sickle Cell Anemia/Trait	[ ]yes [ ]no	17Liver Disease	[ ]yes [ ]no	29 Autism	[ ]yes [ ]no
6 Cleft Palate/Lip	[ ]yes [ ]no	18 Diabetes	[ ]yes [ ]no	30 Behavioral Issues	[ ]yes [ ]no
7 Epilepsy/Seizure	[ ]yes [ ]no	19 Tuberculosis	[ ]yes [ ]no	31 Headaches	[ ]yes [ ]no
8 Intellectual Disability	[ ]yes [ ]no	20 Kidney Problems	[ ]yes [ ]no	32 Developmentally Delayed	[ ]yes [ ]no
9 Growth Problem/Delay	[ ]yes [ ]no	21 Bone/Joint Problem	[ ]yes [ ]no	33 Any allergy to any medication	[ ]yes [ ]no
10 Cerebral Palsy	[ ]yes [ ]no	22 HIV/Aids/ARC	[ ]yes [ ]no	34 Seasonal /Environmental Allergy	[ ]yes [ ]no
11 Ear/Hearing Problem	[ ]yes [ ]no	23 Cancer	[ ]yes [ ]no	35 Food Allergy	[ ]yes [ ]no
12 Speech Delay	[ ]yes [ ]no	24 Chemotherapy	[ ]yes [ ]no		

Please explain by 'number' any of the above marked 'yes': _____

ANY Other Medical Issues *not* noted above: _____

Has your child had ANY surgical procedures in the past year? _____

My Child is taking the following Medications: _____

Are your child's immunizations up to date? Yes No

Child's Physician: _____ Phone Number: _____ last visit: _____

I acknowledge that all the above information has been answered correctly and to the best of my ability. If there are any changes to any of the above information, I will update as needed. I accept complete financial responsibility for my child's account. I understand that I am responsible for *ANY* balance on the account regardless of dental insurance and if I am insured, my signature allows for assignment of benefits directly to Ashley E Hoban DMD PLLC.

Signature of Parent /Guardian _____ **date**____/____/____

Print Parent/Guardian _____