HIGGS PEDIATRIC DENTISTRY
W. Clark Higgs. DDS

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Health History Update

Name_____
Last First MI Preferred

Birthdate_____SS#_____ Gender: Male Female

Home Phone_____ Work Phone_____

Mother's Cell_____ Father's Cell_____

Preferred Contact Method_____

School Patient Attends_____

Home address_____

City_____ State_____ Zip_____

Patient lives with_____
Parents are: Single Married Divorced Separated Widowed

INSURANCE

Patient's relationship to subscriber: Self Spouse Child

Subscriber Name_____ Subscriber ID_____

Insurance Company_____ Phone_____

Employer_____ Group Name_____ Group#_____

Do you have secondary insurance? Yes No
Patient's relationship to subscriber: Self Spouse Child

Subscriber Name_____ Subscriber ID_____

Insurance Company_____ Phone_____

Employer_____ Group Name_____ Group#_____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name_____ Phone Number_____
Relationship_____
Physician's Name _____ Phone Number_____

Is the patient currently under the care of physician? Yes No
Patient's current physical health is: Good Fair Poor
Please list any medications the patient is currently taking and why the patient is taking them:

_____

Are you allergic to any of the following?

___Acrylic ____Sulfa ___Penicillin ___Aspirin
___Tetracycline ____Latex ___Erythromycin ___Metals
___Dental Anesthetics (Epinephrine, Lidocaine, Prilocaine, etc.) ___Food Allergies
Other_____

Has the patient had any of the following diseases, medical problems, or treatments? Please circle all that apply.

Heart Attack/Stroke	Heart Murmur	Heart Surgery	Cleft Palate
Congenital heart defect	Artificial valves	High Blood Pressure	Epilepsy
Low Blood Pressure	Pacemaker	Thyroid	Speech Problems
ADD	Mononucleosis	Hearing Problem	Ulcers/ Colitis
Radiation	Cancer/Chemo	Shingles	Rheumatic Fever
Kidney Disease	Diabetes	Hepatitis	Artificial Joints/bones
Liver	Hemophilia/ Blood Disorder	Blood Transfusion	Cold Sores/ Herpes
Sickle Cell	HIV+/AIDS	Jaw Pain	Anemia
Venereal Disease	Psychiatric care	Drug/Alcohol Addiction	Bone Disorder
ADHD	Neck Pain	Arthritis	Glaucoma
Physical Handicap	Headaches	Sinus Condition	Difficulty Breathing
Delayed Development	Tuberculosis	Asthma Emphysema	Autism
Cerebral Palsy	Mental Handicap	Seizures	Fainting

Other_____

Please Comment: _____

_____

Is there any other concern you would like the dentist to address with you today?

_____

Has the patient been hospitalized recently? Yes No

<u>For female patients</u>

Taking birth control pills? Yes No
Are you pregnant? Yes No
Are you nursing? Yes No

<u>For male patients</u>

Do you take nitroglycerin? Yes No

We use an electronic appointment confirmation system, how do you wish to be sent reminders? <u>Please Circle</u>

Email address: _____ Opt in Opt out

Text message: _____ Opt in Opt out

Phone call: _____ Opt in Opt out

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all medications that are necessary or advisable. I agree to full responsibility for the payment of all fees associated with those services or medications. I understand that the insurance is my responsibility and may not pay as estimated. I understand that payment is due at the time of treatment. If my account requires collection services, I agree to pay all cost incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and interest that may accrue on my account. I authorize the release of information needed by my insurance company to process claims and request that payment be made by my primary/secondary insurance directly to the dentist.

I certify that I, the undersigned, have provided the above child's current health condition accurately. **Sign top line only!**

Patient/ Guardian- Patient 18 and over (sign) _____Date ____/_____/_____

Patient/ Guardian- Patient 18 and over (Initial) _____Date ____/_____/_____

Patient/ Guardian- Patient 18 and over (Initial) _____Date ____/_____/_____

Patient/ Guardian- Patient 18 and over (Initial) _____Date ____/_____/_____

Patient/ Guardian- Patient 18 and over (Initial) _____Date ____/_____/_____