KCDC Health History & Update

Required annually

We strive to make each of your child's visits pleasant and comfortable.

Today's Date: _____ Patient ID # _____

Childs Name: _____

Birthdate: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Cell Number: _____

School: _____ Grade: _____

Mother ___ Stepmother___ Guardian ___ **Father** ___ Stepfather ___ Grandparent ___ Other ___
Other: _____

Name: _____ Name: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____
Employer: _____ Employer: _____
Marital Status ____ Single ____ Married ____ Widowed ___ Divorced ____ Separated

Who is responsible for making appointments? _____ Who is financially responsible? _____

Email address: _____

Deint-Cal / Medi-Cal Number: _____

What is your transportation for appointments? Car bus ride from friend cab walk

How were you referred to this Clinic? _____
What is the reason for your first visit? _____
Who referred you to this Clinic? _____
Medical Subscriber ID:_____

I certify that the statements made on this form are true to the best of my knowledge and I hereby authorize Kids' Community Dental Clinic to make any investigation necessary to confirm this income information. I further acknowledge that this self certification may be subject to further verification by the City of Burbank and/or the U.S. Department of Housing & Urban Development (HUD) and I/We authorize such verification and will provide supporting documents if necessary. As parent or guardian, I certify that I am responsible for this child's health. This is a non-profit clinic operated by volunteers. Please know that we schedule as many children who need treatment and that wait times can be lengthy in order to meet the needs of each individual child.

If not a Medi-Cal patient, here are the financial arrangements:
Cash and checks only for $25 payment due in full at each appointment.
I understand that if I commit to an appointment and cannot make it, I must call to cancel with 24 hour advance notice or I will be responsible for the $25 fee. Non Medi-Cal patients: Our family household income is $_____

(See reverse side for Medical History)

Dental & Health History ***Confidential*** Patient ID # _____

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care that your child receives. Please answer each of the following questions completely.

Is this your child's first visit to the Dentist? ___ yes ___ no

Last dental x-rays? _____

Date of last dental visit? _____

Has your child had difficulty with dental visits? ___ yes ___ no

How often does your child brush? _____

How often does your child floss? _____

Sensitivity to hot, cold and/or sweets? Circle all that apply

Does your child take fluoride supplements? ___ yes ___ no

Does your child: ___ yes ___ no

Does your child drink tap water? ___ yes ___ no

Suck thumb,finger,lip, bite lip, chew nails? ___ yes ___ no

Chew hard objects? (pencils, etc.) ___ yes ___ no

Swelling of face? ___ yes ___ no

Grind teeth? Clench jaws? Clicking jaw? TMJ? ___ yes ___ no

Have any pain? ___ yes ___ no

If in pain – where? _____

Previous Dentist _____

Any sores or growths in the mouth? Where?

Date of last dental visit? _____

Bad breath?

Child's Physician _____

Has your child had difficulty with other dental visits?

Phone # _____

Address _____

Are you currently seeing an orthodontist? __ yes ___ no

(if yes, please list name and phone # of orthodontist)

Name:_____

Phone # _____

List any previous hospitalizations/surgeries/serious illnesses? Has your child had general anesthesia? If so, any complications?

Do you have concerns regarding your child's dental care? _____

Is your child currently taking medications? __ yes __ no (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)?

___ yes ___ no (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? __ yes __no

(if yes, please describe) _____

Has your child had any of the following:

Asthma? ___ yes ___ no

Cancer? ___ yes ___ no

Hepatitis? ___ yes ___ no

HIV/AIDS? ___ yes ___ no

Hemophilia? Or blood disorder? ___ yes ___ no

Sickle cell disease? ___ yes ___ no

Anemia? Jaundice? ___ yes ___ no

Canker sores or cold sores? ___ yes ___ no

Ear infections? Hearing disability? ___ yes ___ no

Eating disorder(s) ___ yes ___ no

A persistent cough or throat clearing? ___ yes ___ no

Thyroid disease? ___ yes ___ no

Nervous disorder? ___ yes ___ no

Abnormal or excessive bleeding? ___ yes ___ no

Lung problems? ___ yes ___ no

ADD? ADHD? ___ yes ___ no

Cerebral palsy? ___ yes ___ no

Developmental disability? ___ yes ___ no

Premature birth? How many weeks? ___ yes ___ no

Arthritis? ___ yes ___ no

Stomach, liver, or kidney problems? Ulcers? ___ yes ___ no

Disabilities? ___ yes ___ no

Tuberculosis? ___ yes ___ no

Diabetes? ___ yes ___ no

Rheumatic fever? ___ yes ___ no

Sexually transmitted disease? ___ yes ___ no

Skin disease? Hives or rashes? ___ yes ___ no

Organ transplants / organ damage? ___ yes ___ no

Anxiety? Depression? ___ yes ___ no

Treatment for emotion, mental, physical delays? ___ yes ___ no

Heart defect/disease/murmur? ___ yes ___ no

Seizures? Convulsions/epilepsy? ___ yes ___ no

Please Explain:_____

High blood pressure? Or Stroke? ___ yes ___ no

Sinus problems? ___ yes ___ no

Autism? ___ yes ___ no

Mental Disability? ___ yes ___ no

Currently pregnant or think you may be pregnant? ___ yes ___ no

History of drug use or smoking? Please explain:_____

Please explain any medical problems that your child has currently or within the past year: _____

Are there any other health history concerns that you would like to bring to our attention? _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I am responsible for this child's health and decisions concerning his/her health. I understand that in this Clinic setting I must cancel appointments within 24 hours. Clinic wait times may be long as priorities go to emergency cases.

Signature of parent or guardian **Date**

☐ My signature below verifies that there are no changes to this form including health history. (Check contact info)

Signature of parent or guardian **Date**

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