KCDC Health History & Update

Required annually

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

Today's Date: _____ Email address _____

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: _____

ANNUAL INCOME INFORMATION (Required)

Mother's Annual Income _____ Father's or guardian's Annual Income _____

List the total number of people in your household _____

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? _____

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. By applying to come to this Clinic, I certify that my child is not covered by any insurance nor are they covered by any government program such as Medi-Cal as this would constitute fraud. 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.

Financial Arrangements: Cash and checks only for $20 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 $20 fee.

(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

Date of last dental visit? _____
How often does your child brush? _____
Is your child's water fluoridated? ___ yes ___ no
Does your child: ___ yes ___ no
Suck thumb/finger? ___ yes ___ no
Suck/bite lip? ___ yes ___ no
Bite/chew nails? ___ yes ___ no
Have any pain? ___ yes ___ no
Previous Dentist _____
Date of last dental visit? _____
Child's Physician _____
Phone # _____
Are you currently seeing an orthodontist? __ yes ___ no
Name:_____

Has your child had difficulty with dental visits? ___ yes ___ no
How often does your child floss? _____
Does your child take fluoride supplements? ___ yes ___ no
Does your child drink tap water? ___ yes ___ no
Chew hard objects? (pencils, etc.) ___ yes ___ no
Grind teeth? ___ yes ___ no
Clench jaws? ___ yes ___ no
If in pain – where? _____
Address _____
Has your child had difficulty with other dental visits?
Address _____

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

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

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
Anemia? ___ yes ___ no
Canker sores or cold sores? ___ yes ___ no
Ear infections? ___ yes ___ no
Eating disorder(s) ___ yes ___ no
A persistent cough or throat clearing? ___ yes ___ no
not associated with a known illness ___ yes ___ no
(lasting more than 3 weeks?) ___ yes ___ no
Abnormal bleeding? ___ yes ___ no

Spina Bifida? ___ yes ___ no
Stomach, liver, or kidney problems? ___ yes ___ no
Handicaps/Disabilities? ___ yes ___ no
Tuberculosis? ___ yes ___ no
Diabetes? ___ yes ___ no
Rheumatic fever? ___ yes ___ no
Sexually transmitted disease? ___ yes ___ no
Skin disease? ___ yes ___ no
Organ transplants / organ damage? ___ yes ___ no
Anxiety? Depression?
Treatment for emotion, mental, physical delays? ___ yes ___ no
Heart defect/disease/murmur? ___ yes ___ no
Seizures? ___ yes ___ no
Convulsions/epilepsy? ___ yes ___ no
High blood pressure? ___ yes ___ no

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 or be responsible for $20 fee and 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**