Kali Smiles Kids
CHILDREN'S DENTISTRY

www.KaliSmilesKids.com | 925.689.5800
675 Contra Costa Blvd., Pleasant Hill, CA 94523

HEALTH HISTORY FORM

Today's Date: _____

Child's Name: _____ Gender ID: ___ Nickname: _____ DOB: ____/____/____

Responsible Party #1 Marital Status: ☐Married ☐ Divorced ☐Single ☐Widowed

Name: _____ Relationship: _____ DOB: ____/____/____

Address: _____

(City) (State) (Zip)

Home #: _____ Work # _____ Ext: _____ Cell #: _____

Social Security Number: _____ Occupation: _____

Email Address: _____

Responsible Party #2 Marital Status: ☐Married ☐ Divorced ☐Single ☐Widowed

Name: _____ Relationship: _____ DOB: ____/____/____

Address: _____

(City) (State) (Zip)

Home #: _____ Work # _____ Ext: _____ Cell #: _____

Social Security Number: _____ Occupation: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

(City) (State) (Zip)

Home #: _____ Work # _____ Ext: _____ Cell #: _____

Primary Dental Insurance ☐No Insurance

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____ Social Security Number: _____

Policy Holders Employer: _____

Insurance Company Name: _____ Group Number: (Plan, Local, or Policy #) _____

Insurance Company Phone Number: _____ Insurance Company Address: _____

Secondary Dental Insurance

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____ Social Security Number: _____

Policy Holders Employer: _____

Insurance Company Name: _____ Group Number: (Plan, Local, or Policy #) _____

Insurance Company Phone Number: _____ Insurance Company Address: _____

Child's Name: _____ Gender ID: ___ Birthday: ____/____/_____

Race / Ethnicity: _____ Height: _____ Weight: _____ Date of last physical exam: _____

Name/Address/Phone of Primary Physician: _____

Name/Address/Phone of Medical Specialist: _____

Is your child being treated by a physician at this time? Reason: _____

Is your child up to date on immunizations against childhood diseases? _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ☐ Yes ☐ No

If yes, list date and describe: _____

Birth / Development

Complications	☐Yes ☐No
Prematurity	☐Yes ☐No
Birth Defects	☐Yes ☐No
Syndroms	☐Yes ☐No
Inherited Conditions	☐Yes ☐No
Developmental problems	☐Yes ☐No

Neurological / Physiological

Impaired vision, hearing or speech	☐Yes ☐No
Developmental delay or intellectual disability	☐Yes ☐No
Cerebral Palsy or brain injury	☐Yes ☐No
Epilepsy or seizures	☐Yes ☐No
Vagal nerve stimulator	☐Yes ☐No
Frequent headaches or fainting	☐Yes ☐No
Hydrocephaly or placement of shunt (VP, VA, VV)	☐Yes ☐No
ADD/ADHD	☐Yes ☐No
Behavioral or psychiatric problems	☐Yes ☐No
Depression or Anxiety	☐Yes ☐No

Heart

Congenital heart defect	☐Yes ☐No
Heart murmur	☐Yes ☐No
Rheumatic heart disease	☐Yes ☐No
Irregular heart beat	☐Yes ☐No
High blood pressure	☐Yes ☐No
Heart Surgery	☐Yes ☐No

Blood

Hemophilia or other bleeding disorder	☐Yes ☐No
Anemia	☐Yes ☐No
Sickle cell disease	☐Yes ☐No
Blood transfusion	☐Yes ☐No
Frequent nosebleeds	☐Yes ☐No

Head & Neck / Sleep

Sinusitis	☐Yes ☐No
Tonsil / Adenoid infections	☐Yes ☐No
Snoring	☐Yes ☐No
Sleep Apnea	☐Yes ☐No
Had a sleep study	☐Yes ☐No

Respiratory

Asthma	☐Yes ☐No
Frequent colds or coughs	☐Yes ☐No
Bronchitis or pneumonia	☐Yes ☐No
Tuberculosis	☐Yes ☐No
Cystic fibrosis	☐Yes ☐No
Heart Surgery	☐Yes ☐No

Musculoskeletal

Artificial joint	☐Yes ☐No
Arthritis	☐Yes ☐No
Limited use of arms/ legs	☐Yes ☐No
Scoliosis / lordosis / kyphosis	☐Yes ☐No

Infectious Disease

HIV/AIDS	☐Yes ☐No
Other	☐Yes ☐No

Digestive

Over or Under Weight	☐Yes ☐No
Hepatitis or liver problems	☐Yes ☐No
GERD or acid reflux	☐Yes ☐No
Stomach ulcers	☐Yes ☐No
Food allergies, dietary restrictions or gluten sensitivity	☐Yes ☐No

Cancer History

Leukemia	☐Yes ☐No
Tumor	☐Yes ☐No
Other malignancy surgery	☐Yes ☐No
Radiation	☐Yes ☐No
Chemotherapy	☐Yes ☐No
Organ transplant	☐Yes ☐No

Endocrine

Diabetes	☐Yes ☐No
Thyroid or pituitary problems	☐Yes ☐No
Precocious puberty or other hormonal problems	☐Yes ☐No

Family History

Malignant Hypothermia	☐Yes ☐No

Females Only

Is there a chance you could be pregnant	☐Yes ☐No
Bladder or kidney problems	☐Yes ☐No
Eczema or other skin problems	☐Yes ☐No

Allergies to any medications? ☐Yes ☐No If Yes, please list: _____

Allergy or reaction to any of the following: ☐Latex ☐Nickel/metal ☐Dental Anesthetic ☐Sedatives ☐Soy ☐Egg yolk ☐None

Is your child taking any medications? ☐Yes ☐No If yes, please list: _____

Dentist's notes:

_____

_____

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

Please initial next to each:

_____I request and authorize dental treatment and procedures for my minor child including the taking of dental x-rays and use of local anesthetics and / or nitrous oxide if necessary.

_____I understand that Kali Smiles Kids will bill my insurance as a courtesy, but that I am ultimately responsible for all charges should my insurance company not pay **within 60 days of treatment.**

_____I understand that my portion is due at the time treatment is rendered. I hereby authorize payment of dental benefits to Kali Smiles Kids

_____I acknowledge that I received the following documents: Dental Material Facts Sheet and HIPAA Notice of Privacy Practices.

Signature: _____ Date: ___/___/_____

Relationship to patient: _____ Are you able to give legal consent for treatment ☐Yes ☐No

Dentist Signature: _____ Date: ___/___/_____