312 Spartanburg Hwy.
Lyman, SC. 29365
tygerriverkidsmiles.com

Office: 864.439.4449
Fax: 864.439.5559
info@tygerriverkidsmiles.com

Child Health/ Dental History Form

Child's name _____ _____
Last First

Date of Birth _____ / _____ / _____

Address _____ _____ _____ _____
Street Address AND APT # City State Zip

Gender ☐ Male ☐ Female

Responsible Party #1:

Name: _____
Relationship: _____ Birthdate: ____/____/____
Social Security #: ____-____-_____ Phone #: (____) ____-_____

Responsible Party #2:

Name: _____
Relationship: _____ Birthdate: ____/____/____
Social Security #: ____-____-_____ Phone #: (____) ____-_____

Emergency Contact:

Name: _____ Relationship: _____
Phone #: (_____) _____-_____

Dental Insurance Information

Primary Dental Insurance:

Insurance company name: _____	Group number: _____	Identification number: _____
Policy owner's name: _____ _____ (LAST / FIRST)	Date of Birth: _____ / _____ / _____	SSN: _____ - _____ - _____
Relationship to child: ☐ mother ☐ father ☐ legal guardian ☐ Other: _____		
Employer: _____		
Address (if applicable): _____ _____ _____ _____ (STREET ADDRESS / CITY / STATE / ZIP)		Phone number: _____

Secondary Dental Insurance:

Insurance company name: _____	Group number: _____	Identification number: _____
Policy owner's name: _____ _____ (LAST / FIRST)	Date of Birth: _____ / _____ / _____	SSN: _____ - _____ - _____
Relationship to child: ☐ mother ☐ father ☐ legal guardian ☐ Other: _____		
Employer: _____		
Address (if applicable): _____ _____ _____ _____ (STREET ADDRESS / CITY / STATE / ZIP)		Phone number: _____

How did you hear about our office? *(Check all that apply)*

☐ Advertisement/Magazine ☐ Family and/or Friends ☐ Website/Search Engine ☐ Ride-By ☐ Other: _____

Please list the name/number of your child's pediatrician as well as any frequently seen specialist, if applicable:

Name of pediatrician: _____ Number: _____

Name of alternate physician/specialist: _____ Number: _____

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Please review carefully and check (✓) if your child has any history of, or condition related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy/Seizures	☐ Latex Allergy	☐ Sickle Cell	☐ STD
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Liver/ Hepatitis	☐ Snoring	☐ Vision disorders
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Measles	☐ Speech/ Hearing	☐ Other:
☐ Autism	☐ Chronic Sinusitis	☐ Headaches	☐ Mononucleosis	☐ Skin	_____
☐ Bladder/Kidney	☐ Diabetes	☐ HIV+/ AIDS	☐ Mumps	☐ Thyroid	_____
☐ Bleeding Disorders	☐ Ear Aches/Infection	☐ Hyperactivity	☐ Pregnancy (teens)	☐ Tobacco/ Drug Use	
☐ Bone Disorders	☐ Enlarged tonsils	☐ ADHD/ ADD	☐ Rheumatic Fever	☐ Tuberculosis	☐ None

Health and Dental History

Yes	No	
☐	☐	1. Does your child require antibiotics before dental treatment?
☐	☐	2. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)? If yes, please list all _____
☐	☐	3. Is your child allergic to (please explain if yes to any):
		a. Any medications? _____
		b. Any foods? _____
		c. Any metals? _____
		d. Seasonal or other? _____
☐	☐	4. Has your child ever been hospitalized or had any type of surgery? Please explain: _____
☐	☐	5. Has your child ever received sedation or general anesthesia?
☐	☐	6. If yes to previous, has your child had any complications with sedation or general anesthesia? Please explain: _____
☐	☐	7. Does your child have any mental, developmental, or physical impairment? Please explain: _____
☐	☐	8. Has your child ever experienced excessive bleeding when cut or injured?
☐	☐	9. Does your child have any genetic or inherited disorders? Please explain: _____
☐	☐	10. Is your child being treated for any other illnesses not yet discussed on this form? Please explain: _____
☐	☐	11. Are your child's immunizations up to date? If not, please explain _____
☐	☐	12. Is this your child's first dental visit? If not, date of last visit? _____
☐	☐	13. Has your child ever had an unfavorable experience or reaction to a previous dental visit? Please explain: _____
☐	☐	14. Have there been any injuries to your child's mouth, teeth, or head? Please explain: _____
		15. What type of water does your child drink (select the most frequent)? ☐ City Water ☐ Bottled water ☐ Filtered water
☐	☐	16. Does your child take fluoride supplements?
☐	☐	17. Is fluoride toothpaste used?
		18. How often are your child's teeth brushed per day? _____ What time of day are they brushed? _____
☐	☐	19. Is the brushing supervised and/ or assisted?
☐	☐	20. Does your child participate in any sports or other recreational activities?
☐	☐	21. Has your child complained of any recent dental pain? Please explain: _____
☐	☐	22. Any other dental concerns/ comments not yet discussed on this form? _____

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Please answer the following questions regarding past and current feeding and other habits:

	Past	Current	N/A
Breast-feeding Age when stopped _____	☐	☐	☐
Bottle use Contents _____ Age when stopped _____	☐	☐	☐
Sippy cup use Contents _____ Age when stopped _____	☐	☐	☐
Thumb/ finger sucking Age when stopped _____	☐	☐	☐
Pacifier use Age when stopped _____	☐	☐	☐
Teeth grinding/ clenching Age when stopped _____	☐	☐	☐

Please read carefully and initial the following statements:

1. I request and authorized dental treatment and procedures for my minor child including the taking of dental X-rays and use of local anesthetics and/or nitrous oxide as may be necessary. _____ *INITIALS*

2. I understand that Tyger River Pediatric Dentistry will bill my dental insurance as a courtesy but that I am ultimately responsible for all charges should my insurance company not pay for any reason. I understand my portion is due at the time treatment is rendered. I hereby authorize payment of dental benefits to Tyger River Pediatric Dentistry, LLC. _____ *INITIALS*

3. I understand that I must provide Tyger River Pediatric Dentistry at least 24-hour notice of a change/cancellation to my child's appointment to avoid a $25.00 broken appointment fee. _____ *INITIALS*

4. I acknowledge that I received the following documents: Notice of Privacy Practices, Office Policies, and Financial Policy. _____ *INITIALS*

As this child's parent or legal guardian, I acknowledge that the completed information in this form is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment.

_____ _____ _____
Parent/ Legal guardian Signature | Print Name | Today's Date

(Sign at the office if completing at home)

Office Use Only	Office Use Only	Office Use Only	Office Use Only

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____
Signature of Dentist **Date**