MARC J HOLLANDER
DDS & ASSOCIATES

118 N. Hamilton Rd, Gahanna, OH 43230 | (614) 344-6844

CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE _____

CHILD'S NAME & NICKNAME _____ DATE OF BIRTH _____

CHILD'S ADDRESS _____ CHILD'S PHONE _____

HOBBIES, SPORTS AND INTERESTS _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RESIDENCE PHONE _____

RESIDENCE ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

DENTAL HISTORY

CHEIF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM _____ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE ☐ YES ☐ NO

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING (PLEASE CHECK):

- ☐ Traumatic injury to mouth or teeth
- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long? _____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Bad Breath
- ☐ Complications from extractions
- ☐ Topical Fluoride Treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits; thumbsucking, fingernail biting, cheek biting, etc.
- ☐ Toothbrush texture _____
- ☐ Brushing frequency _____
- ☐ Dental floss
- ☐ Disclosing tablets/solution
- ☐ Fluoride supplements
- ☐ Between meal snacks
- ☐ Well balanced diet

MEDICAL HISTORY

PHYSICIANS NAME _____ DATE OF LAST PHYSICAL EXAM _____ AGE _____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING (PLEASE CHECK):

- ☐ Allergy to Penicillin
- ☐ Allergies to other drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ Radiation Treatments
- ☐ Excessive bleeding from cut/extraction
- ☐ Anemia or blood problems
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies or Leukemia
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic Fever
- ☐ Immune System Disorders (AIDS,HIV,ARC)
- ☐ Sinus problems
- ☐ Physical or mental handicap
- ☐ Thyroid disorders
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Ulcer or colitis
- ☐ Extreme nervousness

Describe any current medical treatment, including drugs taken, even though not listed above _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and they they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____