KCDC Health History & Update

Required Annually

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

PATIENT INFORMATION

Patient ID# _____ Date: _____

Childs Name: _____ Age: _____ Birthdate: _____

Preferred Pronoun: _____ Sex: Male Female Other: _____

School: _____ Grade: _____

Ethnicity: Hispanic Asian White Black Armenian Other: _____

List siblings attending clinic: _____

PARENT/GUARDIAN INFORMATION

Parents' Name: _____ Parents' Name: _____

Preferred Contact Method: Home Phone Cell Phone Work Phone

Preferred Contact Method: Home Phone Cell Phone Work Phone

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Employer: _____ Employer: _____

Email: _____ Email: _____

Address: _____ Address: _____

City/St/Zip: _____ City/St/Zip: _____

Marital Status: Single Married Divorced Domestic Partner Widow

With whom does the child/children reside? _____

Secondary Adult Consent: (i.e. grandmother, grandfather, aunt, brother…) Individual below may accompany your child to future appointments and give us consent to discuss treatment needs.

Name: _____ Relationship to Child: _____

Phone Number: _____ Alternate Phone Number: _____

Who is responsible for making appointments? _____

Who is financially responsible? _____

Denti-Cal/Medi-Cal #: _____ Total Number of Persons in Household: _____

Total Combined Household Income: $28,400 $35,450 $41,150 $50,000 $60,000 Other: $_____

Transportation to clinic: car bus Uber/Lyft walk ride from friend other: _____

How were you referred to this Clinic? _____

What is the reason for your first visit? _____

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. I understand that this is a non-profit clinic operated by volunteers 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, check, or credit card payments for $30 is 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 $30 fee.

Parent/Guardian Signature _____ Print Name _____ Date _____

Parent/Guardian Signature _____ Print Name _____ Date _____

Confidential Dental & Health History

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? _____
Last dental x-rays? _____
Are you currently seeing an Orthodontist? __ yes __ no
Name of Orthodontist: _____
Orthodontist Phone#: _____
Address: _____
Child's Physician: _____
Address: _____
Physician Phone#: _____
How often does your child brush? 1x day 2x day 3x day 1x week none
How often does your child floss? 1x day 2x day 3x day 1x week none

Has your child had difficulty with dental visits? __ yes __ no
If in pain – where? _____ __ yes __ no
Any sores or growths in the mouth? __ yes __ no
List where sores are: _____
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? Clench jaws? Clicking jaw? TMJ? __ yes __ no
Sensitivity to hot, cold and/or sweets? __ yes __ no
Suck thumb, finger, lip, bite lip, chew nails? __ yes __ no
Swelling of face? __ yes __ no
Bad breath? __ yes __ no

Has your child had any of the following:

Abnormal or Excessive Bleeding?	__ yes	__ no	Fractured Jaw?	__ yes	__ no
ADD? ADHD? Autsim?	__ yes	__ no	Heart Defect, Disease or Murmur?	__ yes	__ no
Anemia? Jaundice?	__ yes	__ no	Hepatitis?	__ yes	__ no
Anxiety? Depression?	__ yes	__ no	High Blood Pressure or Stroke?	__ yes	__ no
Arthritis?	__ yes	__ no	HIV/AIDS?	__ yes	__ no
Asthma? Allergy? Sinus Promblems?	__ yes	__ no	Lung Problems?	__ yes	__ no
Brain Injury or Concussion?	__ yes	__ no	Nervous Disorder, Anxiety or Depression?	__ yes	__ no
Blood Disorders? Hemophilia? Leukemia? Anemia?	__ yes	__ no	Organ Transplants or Organ Damage?	__ yes	__ no
Cancer? Tumors? Chemo or Radiation Treatments?	__ yes	__ no	Persistent Cough or Throat Clearing?	__ yes	__ no
Canker Sores or Cold Sores?	__ yes	__ no	Premature Birth? How many weeks?_____	__ yes	__ no
Cerebral Palsy?	__ yes	__ no	Rheumatic Fever?	__ yes	__ no
Congenital Birth Defect?	__ yes	__ no	Skin Disease? Hives or Rashes?	__ yes	__ no
Currently pregnant or think you may be pregnant?	__ yes	__ no	Stomach, Liver, or Kidney Problems?	__ yes	__ no
Diabetes?	__ yes	__ no	Thyroid Disease?	__ yes	__ no
Disabilities - Mental, Physical or Developmental?	__ yes	__ no	Treatment for Emotionional, Mental, or Physical Delays?	__ yes	__ no
Ear Infections? Hearing Disability?	__ yes	__ no			
Eating Disorder?	__ yes	__ no	Tuberculosis?	__ yes	__ no

List any previous hospitalizations/surgeries/serious illnesses:

Has your child had general anesthesia? If so, please list any complications: __ yes __ no

Is your child currently taking medications? Please list all medications: __ yes __ no

Do you have concerns regarding your child's dental care? Please list: __ yes __ no

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.) __ yes __ no

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? Please List: __ yes __ no

Has your child had experienced any seizures, convulsions or epilepsy? Please explain: __ yes __ no

History of drug use, smoking or vaping? Please explain: __ 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.

Parent/Guardian Signature	Print Name	Date
Parent/Guardian Signature	Print Name	Date