SIGMA DENTAL

CHILD'S HEALTH QUESTIONNAIRE

Patient and Family Information

Child's Name _____ Birthdate _____ ☐Male ☐Female
Social Security # _____ Home Phone _____
Home Address _____
City _____ State _____ Zip _____
School _____ Grade _____
Responsible Party _____
Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____

Name of Father/Guardian _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____

Child's Dental History

Former Dentist _____ Office Phone _____
Address _____
City _____ State _____ Zip _____
Date of last dental visit _____
How often does your child brush? _____
How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth
☐ Lip or Cheek Biting ☐ Jaw Difficulty:Clicking and/or Pain

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Epilepsy ☐ Scarlet Fever
☐ Anemia ☐ HIV/AIDS ☐ Tonsillitis

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- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Hepatitis -Type _____
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Other _____

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____