



GAIL V. PLAUKA, D.M.D. and Associates

### Health History

The following information and history are necessary for adequate treatment and understanding of your child. This record is confidential and for use only within this office. Thank you for completing it in full.

Patient's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Sex \_\_\_\_\_ Hobbies \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 His Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 His Email address \_\_\_\_\_ His Cell Phone \_\_\_\_\_  
 Where Employed \_\_\_\_\_ Phone \_\_\_\_\_  
 Father's Dental Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
 Father's Major Medical Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
 Her Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
 Her Email address \_\_\_\_\_ Her Cell Phone \_\_\_\_\_  
 Where Employed \_\_\_\_\_ Phone \_\_\_\_\_  
 Mother's Dental Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
 Mother's Major Medical Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
 With whom does patient live? \_\_\_\_\_  
 Phone numbers for confirmation of Appts. - Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_  
 Have any members of your family been a patient of this office before? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Give names and ages \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

I accept financial responsibility for all services rendered to my child. The parent or guardian bringing the patient to our office is responsible for payment of the account. I authorize the release of any medical information to process my insurance claims or payment assigned to Gail V. Plauka, D.M.D., P.C. and associates. This office will assist in the prompt filing of all insurance forms; however, I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for any services not covered by my policy. In the event of default on my account, I agree to pay collection costs including attorney's fees and court costs which may represent one third of the balance due.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL HEALTH HISTORY

Condition of child's general health \_\_\_\_\_  
 Child's Physician \_\_\_\_\_ Phone# \_\_\_\_\_  
 Family Dentist \_\_\_\_\_ Phone# \_\_\_\_\_

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have regular medical exams?
<input type="checkbox"/>	<input type="checkbox"/>	Is your child up to date with immunizations?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child been hospitalized since birth? Date _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had general anesthesia or sedation for medical reasons? Date _____ Reason _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your child presently taking medications? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had blood transfusions?
<input type="checkbox"/>	<input type="checkbox"/>	Is your child presently undergoing any medical treatment? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your child presently undergoing chemotherapy?
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have an infectious or chronic disease? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does your child smoke or use tobacco products?
<input type="checkbox"/>	<input type="checkbox"/>	Is your child allergic to any Medicine? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your child allergic to Latex?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child experienced any unfavorable reactions from previous dental or medical care? If yes, please explain. _____

Comments: \_\_\_\_\_

(Over)

Has your child ever received medical treatment related to the following organ systems?

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Blood-Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal-Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Muscles
<input type="checkbox"/>	<input type="checkbox"/>	Bones	<input type="checkbox"/>	<input type="checkbox"/>	Kidney-Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Valves and Joints
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Skin Throat
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoids			

If so, please explain \_\_\_\_\_

Has your child ever received medical treatment related to the following conditions?

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS (Immunosuppressive Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Polio
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats - Frequent
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Kawasaki Disease	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Syndrom _____
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other
			<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia			

**DENTAL HEALTH HISTORY**

<b>YES</b>	<b>NO</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have a dental condition about which you are especially concerned? If yes, please explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Is this your child's first visit to the dentist? If not, date of last dental care? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever received injuries to the head, jaw, mouth or teeth? If yes, describe _____
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have a toothache?
<input type="checkbox"/>	<input type="checkbox"/>	Was your child a thumb/finger sucker? Age discontinued? _____
<input type="checkbox"/>	<input type="checkbox"/>	Did your child use a pacifier? Age discontinued? _____
<input type="checkbox"/>	<input type="checkbox"/>	Was your child bottle-fed? Age discontinued? _____
<input type="checkbox"/>	<input type="checkbox"/>	Was your child breast-fed? Age discontinued? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is your child a mouth breather?
<input type="checkbox"/>	<input type="checkbox"/>	Does your child grind or clench his/her teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Do your child's gums bleed?
<input type="checkbox"/>	<input type="checkbox"/>	Is your child presently taking a fluoride supplement? If so, what? _____
<input type="checkbox"/>	<input type="checkbox"/>	What is your water source? Public System _____ Private Well _____ Reverse Osmosis System _____
<input type="checkbox"/>	<input type="checkbox"/>	How often are your child's teeth brushed per day? _____ By whom? _____ What type of toothpaste? _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. Plauka, her associates and other healthcare professionals on her staff responsible for any errors or omissions I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Parent or Legal Guardian      Relationship to patient      Witness      Date