halex PEDIATRIC DENTISTRY

Annual Health History Update

Patient's Name: _____ **Date of Visit:** _____ **Date of Birth:** _____

What is the reason for completing this form today:

☐ Treatment ☐ Treatment w/Nitrous ☐ Treatment w/Sedation ☐ 12-month Renewal

Primary Address of Patient: _____

Primary Phone number: _____ **Primary email:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Indicate changes to the following: (check all that apply): ☐ Marital Status | ☐Insurance | ☐Address/Phone/Email | ☐Primary Guardianship | ☐ Other _____

MEDICAL HISTORY

Are immunizations current: ☐ Yes ☐ No

Child's physician: _____ **Phone:** _____ **Date Last Exam:** _____

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain):

_____

Current Medications: _____

Has your child been diagnosed and/or treated for any medical conditions?

YES	NO		YES	NO		YES	NO	
☐	☐	Complications before/at birth, prematurity, inherited conditions, syndromes, or birth defects	☐	☐	Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐	☐	Cancer, tumor, or other malignancy; chemotherapy, radiation, or transplant
☐	☐	Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	☐	☐	Prolonged diarrhea, unintentional weight loss, weight concerns, or eating disorder	☐	☐	Behavioral, emotional, communication, or psychiatric problems/treatment
☐	☐	Sinusitis, chronic adenoid/tonsil infections	☐	☐	Bladder or kidney problems or bedwetting	☐	☐	Attention deficit/hyperactivity disorder (ADD/ ADHD)
☐	☐	Developmental disorders, learning problems/ delays, or intellectual disability	☐	☐	Fine/gross motor deficits, arthritis, limited use of arms/legs, or muscle/bone/joint problems, or scoliosis	☐	☐	Abuse (physical, psychological, emotional, or sexual) or neglect
☐	☐	Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐	☐	Recurrent headaches/migraines, fainting, or dizziness	☐	☐	Precocious puberty or hormonal problems
☐	☐	Irregular heartbeat or high blood pressure	☐	☐	Diabetes, hyperglycemia, or hypoglycemia	☐	☐	Thyroid or pituitary problems
☐	☐	Asthma, reactive airway disease, wheezing, or breathing problems	☐	☐	Impaired vision, visual processing, hearing, or speech	☐	☐	Anemia, sickle cell disease/trait, or blood disorder
☐	☐	Cystic fibrosis	☐	☐	Problems with physical growth or development	☐	☐	Hemophilia, bruising easily, or excessive bleeding
☐	☐	Frequent colds/coughs, bronchitis, or pneumonia	☐	☐	Transfusions or receiving blood products	☐	☐	Sleep apnea, snoring, or mouth breathing
☐	☐	Frequent exposure to tobacco smoke	☐	☐	Rash/hives, eczema, or skin problems	☐	☐	Jaundice, hepatitis, or liver problems
☐	☐	Autism/autism spectrum disorder or sensory integration disorder	☐	☐	GERD/acid reflux, stomach ulcer, or intestinal problems	☐	☐	COVID-19, CMV, HIV/AIDS, MRSA, mononucleosis, scarlet fever, STD, or TB
☐	☐	Hydrocephaly or placement of a shunt						

Please explain any "YES" answers:

_____

Other conditions not listed above (please specify):

_____

ALLERGIES ☐ DRUGS _____ ☐ FOOD _____ ☐LATEX _____ ☐OTHER _____

_____ _____ _____ _____

If there is any additional information that you think might be of value to us in treating your child, please feel free to notate on this form.

DISCLOSURE: Please be informed that our staff will never guarantee coverage or payment by your insurance provider for services rendered by our office. You hold financial responsibility for all services rendered.

I certify that the information I have given is correct to the best of my knowledge. If there is any additional information that you think might be of value to us in treating your child, please feel free to notate it on this form. The information will be held in confidence, and it is my responsibility to inform this office of changes in the patient's medical status. I will not hold Dr. H. Bobby Garofalis and his associates, or his staff, responsible for any errors or omissions I may have made in the completion of this form. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Dr. H. Bobby Garofalis & Associates all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, up to 33 1/3%, court filing fees and attorney fees.

Name of Adult with the patient today **Relation to Patient:**

_____ _____

Parent/Guardian Signature: **Date:**

_____ _____

Halex Front Desk Signature: **Date:**

_____ _____