jlh JEFFREY L. HARDENBURG D.D.S.

Family & Cosmetic Dentistry
G-7233 Fenton Road Grand Blanc, MI 48439
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Child's Medical & Dental

Patient Name _____ **DOB** _____ **Gender** male ○ female ○

Welcome! *So that we may provide you with the best possible care*
please complete both Medical History and Dental History information.
All information is completely confidential.

What is the reason for his/her visit today?

Who may we thank for referring you to our practice?

Date of last dental visit? _____ Last dental cleaning? _____ Last full mouth xrays? _____

What was done on his/her last visit?

yes	no	
○	○	Has child complained about dental problems?
○	○	Does your child brush teeth daily?
○	○	Does your child use floss regularly?
○	○	Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?

yes	no	**Any:**
○	○	Fluoride taken in any form?
○	○	Injuries to mouth, teeth, head?
○	○	Unhappy dental experiences? If yes explain:

Last dentist's name? _____ City _____ State _____ Phone: _____
Child's Physician? _____ City _____ State _____ Phone: _____
Date of last physical exam? _____ Results: _____
Any Medications? **yes** ○ **no** ○ If yes please list:

Any Allergies? **yes** ○ **no** ○ If yes please list:

yes	no	
○	○	Has child had excessive bleeding when cut?
○	○	Is child under physician care now? If yes please explain:

yes	no	
○	○	Has child been hospitalized?
○	○	Has child had surgery?

Has child had any history of:

yes	no		yes	no		yes	no	
○	○	AIDS/HIV	○	○	Epilepsy	○	○	Pschological Problems
○	○	Anemia	○	○	Fainting	○	○	Rheumatic Fever
○	○	Asthma	○	○	Hearing Problems	○	○	Sinus Problems
○	○	Cancer	○	○	Heart Problems	○	○	Thyroid Disease
○	○	Cerebral Palsy	○	○	Hepatitis	○	○	Tuberculosis
○	○	Convulsions	○	○	Kidney Disease	○	○	Other? If yes explain:
○	○	Diabetes	○	○	Learning Disabilities			
○	○	Drug/Alcohol Abuse	○	○	Liver Disease			

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr Hardenburg if my minor/child ever has a change in health.

Patient/Guardian Signature:_____ **Date:** _____

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Child's Medical & Dental
continued

Minor/Child Consent **Please enter name of Minor/Child below**

I am the parent, guardian, or personal representative of: _____
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release **Please enter insurance company name below**

I certify that my dependent(s) is covered by insurance with _____
and assign directly to Dr. Jeffrey L. Hardenburg D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
Dr. Hardenburg may use my minor/child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Name of parent, guardian or personal representative _____

Date _____

Signature of parent, guardian or personal representative _____

Relationship to patient _____

Notes: (for office use only)

Date _____ Dentist Signature_____

Please bring a completed copy of this form with you on your scheduled office appointment.

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