Polished, LLC Health History

Child's Information (Please print):

Child's Name: _____ _____ M ☐ F ☐ **Child's Birthday**: ____/____/____
(first) (last) (month) (day) (**birth year**)

School: _____ Grade: _____ Room: _____ Teacher:_____

Child's primary language: _____Parent's primary language:_____

Parent's name and address: _____

Email_____ Parent's day time phone: _____

Dental Information:

1. Date of last dental check-up: _____
2. My child has a local dentist YES ☐ NO ☐ Dentist name: _____
   If not, we will provide a list of dentists in your area.
3. My child needs to take antibiotics before having dental treatment ☐YES Why?_____ ☐ NO
4. Please tell us about your child's dental experience._____

Medical Information:

1. My child has had serious health problems YES ☐ NO ☐
2. My child is under a doctor's care now. YES ☐ for_____ NO ☐
3. My child has now or had before: Anemia ☐ Asthma ☐ Convulsions ☐ Diabetes ☐ Epilepsy ☐Seizures☐ Glaucoma ☐ Heart Problems:☐ Heart Murmur ☐ Heart valve replacement ☐Hepatitis ☐ Kidney/ Liver ☐ Rheumatic Fever ☐ Joint replacement ☐ Immune Disorder /HIV/ AIDS ☐ Tuberculosis☐ Other:_____
4. My child is taking medicine YES ☐ name of medicine_____ NO ☐
5. My child is allergic to: Penicillin☐ Antibiotics ☐ Aspirin ☐ Latex ☐ Foods ☐ Other:_____

Other Demographic Information:

The following information is for the Commonwealth of Massachusetts.

My child is: Black/ African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐
Native Hawaiian/ Pacific Islander ☐ Hispanic ☐ More than one race ☐
I do not wish to answer ☐

Insurance Information

My child has the following dental insurance:

☐ **No Dental Insurance**

☐ **MassHealth** RID Number: _ _ _ _ _ _ _ _ _ _ _ _ _

☐ **Delta** ☐ **BC/BS** ☐ **Other** _____

Individual Policy#_____

Group Policy # _____

Subscriber Information

Subscriber Name: _____Subscriber ID: _____

Subscriber _____Employer Name:_____ Subscriber Date of Birth: Month_ _ Day_ _ Year_ _ _ _

I agree that the above health information is correct.
I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com**; phone (508) 237-5378.**

SIGN HERE Parent/Guardian:

▶ _____**Date:** _____