CHILD PATIENT INFORMATION

DATE_____

CHILD'S NAME: _____
GENDER (M/F): _____
BIRTHDATE_____ AGE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE #'S: HOME#:_____ EMERGENCY#:_____
SCHOOL: _____

PARENTAL INFORMATION

PERSON RESPONSIBLE FOR SCHEDULING & BRINGING CHILD TO APPOINTMENTS AND PAYMENT OF ACCOUNT: _____

FATHER'S NAME: _____ S.S.#: _____
MARITAL STATUS: _____ BIRTHDATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE:_____
PHONE #'S: HOME_____WORK_____CELLULAR_____
FATHER EMPLOYED BY: _____
MOTHER'S NAME: _____ S.S.#: _____
MARITAL STATUS: _____ BIRTHDATE: _____
ADDRESS: _____
CITY _____ STATE _____ ZIP CODE_____
PHONE #'S: HOME_____WORK_____CELLULAR_____
MOTHER EMPLOYED BY: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE:
PATIENT'S RELATIONSHIP TO INSURED:
SELF _____ SPOUSE _____ CHILD _____ OTHER _____
NAME OF INSURED: _____
INSURED'S BIRTH DATE: _____ SS#: _____
INSURED'S ADDRESS:_____
EMPLOYER: _____

SECONDARY INSURANCE:
PATIENT'S RELATIONSHIP TO INSURED:
SELF _____ SPOUSE _____ CHILD _____ OTHER _____
NAME OF INSURED: _____
INSURED'S BIRTH DATE: _____ SS#: _____
INSURED'S ADDRESS: _____
EMPLOYER: _____

(OVER)

HEALTH HISTORY

NAME OF MEDICAL DOCTOR: _____

ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE …… YES NO

ARE YOU TAKING ANY MEDICATION INCLUDING BIRTH CONTROL PILLS YES NO

NAMES OF MEDICATIONS: _____

DO YOU USE ANY RECREATIONAL DRUGS, INCLUDING COCAINE …… YES NO

ARE YOU AN ALCHOHOLIC ……. YES NO

DO YOU USE ANY TOBACCO PRODUCTS ……. YES NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

ALLERGIES, INCLUDING ANY MEDICATIONS …… YES NO

IF ALLERGIES, TO WHAT? _____

METAL REACTIONS …… YES NO

HEART DISEASE ……. YES NO

IF YES, WHAT TYPE? _____

RHEUMATIC FEVER ……. YES NO

HEART MURMER ……. YES NO

IF YES, WHAT TYPE? _____

HAVE YOU HAD HEART VALVE PROBLEMS INCLUDING MVP OR VALVE REPLACEMENT …… YES NO

HIGH BLOOD PRESSURE …….. YES NO

KIDNEY DISEASE …….. YES NO

LIVER DISEASE …….. YES NO

HEPATITIS …….. YES NO

AIDS OR OTHER IMMUNE DISORDER …….. YES NO

ASTHMA …….. YES NO

TUBERCULOSIS …… YES NO

DIABETES …… YES NO

EPILEPSY ……. YES NO

ANEMIA …… YES NO

VENERAL DISEASE …….. YES NO

CANCER …….. YES NO

IF YES, WHAT TYPE? _____

JOINT REPLACEMENT …… YES NO

IF YES, WHICH JOINT(S), WHEN, WHO PERFORMED THE SURGERY?

_____

HAVE YOU EXPERIENCED PROLONGED BLEEDING …… YES NO

HAVE YOU HAD AN UNUSUAL REACTION TO AN **ANESTHETIC** OR **DRUG** … YES NO

ARE YOU ALLERGIC TO **PENICILLIN, NOVACAINE,** OR **LATEX**…… YES NO

FEMALE PATIENTS: ARE YOU PREGNANT ……. YES NO

IF YES, WHAT IS THE DUE DATE? _____

IS THERE ANY OTHER INFORMATION THAT WOULD BE IMPORTANT RELATING TO YOUR MEDICAL OR DENTAL HEALTH? _____

DATE OF LAST DENTAL VISIT:_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

SIGNATURE: _____

(Patient or Parent if minor)