PATIENT INFORMATION & HEALTH HISTORY

Child's name_____Nickname_____Male_____Female_____
Address_____City_____State_____Zip_____
Date of Birth_____Age_____
Father_____Cell #_____
Date of Birth_____SSC# (required for insurance) _____
Address_____City_____State_____Zip_____
Employer_____Insurance Company_____
Mother_____Cell #_____
Date of Birth_____SSC# (required for insurance) _____
Address_____City_____State_____Zip_____
Employer_____Insurance Company_____

Is your child taking any prescription and/or over the counter medications or vitamin supplements currently? If yes, please list:

_____

Is your child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain:

_____

Is your child allergic to anything else, such as certain foods? If yes, please explain:

_____

Any history of diabetes, kidney, or liver problems with your child? _____

Does your child have asthma or breathing problems? _____Medication_____

Is your child currently taking any medications? _____

Has your child ever tested positive to any of the following?

Hep A (infectious) _____ Hep B (Serum) _____ HIV (AIDS) _____

Has your child ever had a serious illness? If yes, when: _____

Has your child ever been hospitalized? _____

Has your child ever received a general anesthetic? _____

Does your child have any speech difficulties? _____

Has your child ever had a blood transfusion? _____

Is your child physically, mentally, or emotionally impaired? _____

Does your child experience excessive bleeding when cut? _____

Is this your child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____

Has your child had any problem with dental treatment in the past? _____

Has your child ever suffered any injuries to the mouth, head or teeth? _____

Does your child suck his/her thumb, fingers or pacifier? _____

At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____

Referring Dentist: _____
Pediatrician (Physician) _____Phone #_____

Signature_____Date_____