Blanchard Valley Pediatric Dentistry
Kyle D. Amspaugh, DDS, MS

PARENT & PATIENT INFORMATION

Date _____

CHILD'S NAME _____ Nickname _____

Date of Birth _____Male_____Female_____

Home Address _____City _____Zip _____

FATHER _____ Social Security # (Required for Insurance) _____

Date of Birth _____Employer _____Occupation _____Work # _____

Home Address_____City_____Zip_____ Cell Phone:_____

MOTHER _____ Social Security # (Required for Insurance) _____

Date of Birth_____ Employer _____Occupation _____Work # _____

Home Address _____City _____Zip _____ Cell Phone:_____

INSURANCE: Is your child covered by dental insurance? **YES** □ **NO** □

Name of parent insured _____ Insurance Company _____

Employer _____

Secondary (if any):
Name of parent insured _____ Insurance Company _____

Employer _____

PATIENT HEALTH HISTORY

Child's name_____

Is your child taking to any prescription and/or over the counter medications or vitamin supplements currently?

_____

Is your child allergic to any medications, i.e. Penicillin, antibiotics, or other drugs?

_____

Is your child allergic to certain foods or dyes?

_____

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

_____

Does your child have asthma or breathing problems? _____ Medication_____

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

Heb A (infectious) _____ Heb B (serum) _____ HIV (AIDS) _____

Has your child ever had a serious illness? _____

Has your child ever been hospitalized? Why? _____

Has your child ever received a general anesthetic? Why? _____

Has your child ever had a blood transfusion? _____

Does your child experience excessive bleeding when cut? _____

Does your child have any speech difficulties? _____

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

Is this your child's first visit to a dentist? _____

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

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

At what age did your child stop bottle feeding? _____ Breast feeding? _____

Pediatrician (Physician) _____ Phone # _____

Referring Dentist _____

I HAVE READ AND RECEIVED A COPY OF THE HIPPA CONSENT FORM, FINANCIAL POLICY, AND APPOINTMENT POLICY.

Signature _____ Date _____