CHILD PATIENT HISTORY

Date ______________________

Child's Name ________________________________ Sex [ ] M [ ] F Date of Birth_____/_____/_______(mm/dd/yyyy)

Street Address ____ Home phone _______-_______-_________

City ____ State __________ Zip Code __________

Father ____ Cell phone _______-_______-_______

Email address ____ Work phone _______-_______-_______

Mother ____ Cell phone _______-_______-_______

Email address ____ Work phone _______-_______-_______

How did you hear about our office: [ ] Referred [ ] Insurance Company [ ] Website [ ] Other ______________

MEDICAL HISTORY:

Physician's Name ____ Phone _______-_______-_______

Date of last physical ______________________________ Results: [ ] Excellent [ ] Fair [ ] Poor

Is child being treated for any medical condition? YES NO Does child bleed excessively for a cut or extraction? YES NO

Is child required to take antibiotic premedication before dental treatment? YES NO Has child ever been hospitalized? YES NO

If yes, explain: ____

List all medications child is currently taking:

____

____

____

____

____

ALLERGIES: [ ] **NONE**

[ ] Aspirin
[ ] Nuts ______________
[ ] Codeine
[ ] Metals
[ ] Latex
[ ] Local Anesthetic
[ ] Food Dyes
[ ] Penicillin / Antibiotics
[ ] Sulfa
[ ] Other______________

Circle Y for **YES** or **N** for **NO** if your child has ever had / has any of the following:

Y N ADD / ADHD	Y N Bruising Problems	Y N Heart Murmur	Y N Psychiatric Disorder
Y N AIDS / HIV Positive	Y N Cancer	Y N Hemophilia	Y N Rheumatic Fever
Y N Anemia	Y N Cerebral Palsy	Y N Hepatitis / Liver Problems	Y N Sickle Cell Disease / Trait
Y N Artificial Bones / Joints	Y N Congenital Heart Defect	Y N Kidney Disease	Y N Seizures / Epilepsy
Y N Asperger Syndrome	Y N Diabetes	Y N Learning Problems	Y N Transfusion
Y N Asthma	Y N Eye Problems	Y N Mental Retardation	Y N Tuberculosis (TB)
Y N Autism	Y N Fainting	Y N Mononucleosis	Y N Yellow Jaundice
Y N Bleeding Problems	Y N Febrile Seizures	Y N Physical Disability	
Y N Brain Injury	Y N Hearing Loss	Y N Pregnancy	

Has your child ever had any illness or medical condition not listed.. YES NO

If yes, explain ____

DENTAL HISTORY

Reason for visit: [ ] Consult / Examination [ ] Pain [ ] New Patient

Last dental visit: [ ] First visit date of last visit ____________________

Circle Y for YES or N for NO if your child does or has done any of the following:

Y N Finger / Thumb Sucking **Y N** Nail biting **Y N** Pacifier **Y N** Nursing / Bottle

Y N Well water **Y N** Fluoride Supplements **Y N** Injuries to mouth / teeth / head

Y N Unhappy dental experience **Y N** Current dental issues / problems

Has the child ever had a serious / difficult problem associated with previous dental treatment? **YES NO**

If yes, explain ____

INSURANCE INFORMATION:

Insurance Co. Name ____________ Phone ___-___-___ Group#(Plan, Local or Policy#) ________

Insurance Co. Address ____

Subscriber's Name ____________________ Relationship to patient ____________

Subscriber's Birthdate ___/___/_____ (mm/dd/yyyy) SSN/ID# ____________

Subscriber's Employer ____________________ Work phone ___-___-___

I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for balance not covered by my insurance. I authorize the use of my signature on all of my insurance submissions, whether manual or electronic.

____

Parent / Guardian Signature