Child / Minor Patient Information and Health History

Patient Information

Last Name_____First Name_____MI_____

Address _____
(Street) (City, State) (Zip)

Home # (_____)_____-_____ Birth Date _____/_____/_____ Current Age_____ Sex F M

Soc. Sec. #_____-_____-_____ Reason For Today's Visit?_____

Parent / Guardian Information

Last Name_____First Name_____MI_____

Address _____
(Street) (City, State) (Zip)

Home #(_____)_____-_____ Work #(_____)_____-_____ Cell/Pager #(_____)_____-_____

Birth Date _____/_____/_____ Soc. Sec. #_____-_____-_____ Relationship to Child _____
Circle One --- Single Married Divorced Widowed

Employer Name and Address_____
Job Title / Occupation_____ Date Started_____

Other Parent / Guardian Information

Last Name_____First Name_____MI_____

Address _____
(Street) (City, State) (Zip)

Home #(_____)_____-_____ Work #(_____)_____-_____ Cell/Pager #(_____)_____-_____

Birth Date _____/_____/_____ Soc. Sec. #_____-_____-_____ Relationship to Child_____
Circle One --- Single Married Divorced Widowed

Employer Name and Address_____
Job Title / Occupation_____ Date Started _____

Insurance Information

Name of Insured _____
Emloyee SSN_____-_____-_____ Birth Date_____/_____/_____Relationship to Patient_____
Insurance Company Name & Address _____
_____
Insurance Company Phone #_____ Group #_____

Name of closest relative not living with you_____
Relative's Address_____
(Street) (City, State) (Zip)
Relationship_____Home Phone #(_____)_____-_____

Additional Information

How did you find out about our office? _____
Are you under the care of a physician at this time? If so, what are you being treated for?_____
Name of Treating Physician_____
Have you ever been required to Premedicate with an Antibiotic prior to a Dental work? Y N
Have you been hospitalized within the past year? Y N
If so, what for?_____

Dental History

When was your child's last visit to a dental office? _____ What was done? _____

Does your Child have braces? Y N If so, when were they placed?_____

Name and Location of Treating Orthodontist_____

Does your child suck his or her thumb? Y N If yes, Has this become a problem?_____

Medical Information

Please look over this list and check anything that your child may have had or has currently.

___Abnormal Blood Pressure
___AIDS
___Allergies
___Anemia
___Angina
___Arthritis
___Artificial Heart Valve(s)
___Artificial Joint(s)
___Asthma
___Blood Disorders
___Blood Pressure (HIGH)
___Blood Pressure (LOW)
___Blood Transfusion
___Bruise Easily
___Cancer
___Chemotherapy
___Chronic Cough
___Cold Sores
___Congenital Heart Disease
___Congestive Heart Failure
___Cortisone Medication
___Cosmetic Surgery
___Diabetes
___Drug Dependency
___Epilepsy
___Fainting Spells
___Glaucoma
___Heart Disease/Attack
___Heart Murmur
___Heart Pacemaker
___Heart Surgery
___Hemophilia
___Hepatitis A (Infectious)
___Hepatitis B (Serum)
___Herpes
___HIV Positive
___Jaundice
___Kidney Problems
___Leukemia
___Liver Disease
___Meningitis
___Mitral Valve Prolapse
___Organ Transplant
___Polio
___Psychiatric Treatment
___Radiation Therapy
___Rheumatic Fever
___Rheumatism
___Scarlet Fever
___Seizures
___Sickle Cell Disease
___Sinus Trouble
___Stroke
___Thyroid Disease
___TMJ (Pain in Jaw Joints)
___Tuberculosis
___Ulcers
___Venereal Disease
___X-ray/Cobalt Treatment

Other (Please Indicate) _____

Is your child currently taking any medication? Y N If So, Please List _____

_____

Are You Allergic Or Have You Reacted Adversely To

Local Anesthetics (Novocaine/Xylocaine) Y N
Aspirin Y N
Sulfa Drugs Y N
Codeine Y N
Other Narcotics Y N
Please List_____
Penicillin Y N
Other Antibiotics Y N

Please List _____
Metals Or Jewelry Y N
Latex Y N
Other Allergies Please List _____
_____
_____
_____

Please Read Carefully And Sign

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in any of this information, I will inform the office at the next appointment. I do hereby authorize any dental service or procedure the doctor may deem necessary, for the above named patient. I also authorize the administration of those local anesthetics or premedications which may be deemed advisable. I will be responsible for any financial obligation for treatment for the above named patient.

X_____ _____ ____/____/____

Signature of Responsible Party Relationship Date

_____

Staff Member Signature