Child Information and Health History

PATIENT INFORMATION **TODAY'S DATE** _______________

LAST NAME FIRST NAME INITIAL

DATE OF BIRTH PERSON RESPONSIBLE FOR THIS ACCOUNT - RELATION

MAILING ADDRESS CITY STATE ZIP CODE

PHYSICAL ADDRESS CITY STATE ZIP CODE

PARENT/GUARDIAN INFORMATION

LAST NAME FIRST NAME INITIAL

DATE OF BIRTH SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER

HOME PHONE NUMBER WORK PHONE NUMBER EXTENSION

CELL PHONE NUMBER EMAIL ADDRESS

EMPLOYER NAME & ADDRESS CITY STATE ZIP CODE

PREFERRED METHOD OF CONTACT EMERGENCY CONTACT (NON SPOUSE)

SPOUSE NAME CONTACT NUMBER DATE OF BIRTH

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER INSURED PERSON DATE OF BIRTH

ID NUMBER OR SSN GROUP NUMBER EMPLOYER

INSURANCE MAILING ADDRESS CITY STATE ZIP

SECONDARY INSURANCE CARRIER INSURED PERSON DATE OF BIRTH

ID NUMBER OR SSN GROUP NUMBER EMPLOYER

INSURANCE MAILING ADDRESS CITY STATE ZIP

Patient Name____ Date of Birth ____________

(Last) (MI) (First)

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE <u>DON'T KNOW</u> ON THE LINE AFTER THE QUESTION.

1. Are you under a Physician's care?………………………………………. YES NO
   Physician's Name____
   Phone Number ____
2. When was your last complete physical exam?…………………………...__________
3. Are taking any medication or substances?………………………………. YES NO
   (If yes, please list medications in the "comments" box to the right)
4. Do you routinely take health related substances? (ig: St. John's Wart)…... YES NO
5. Are you allergic to any medications or substances?…………………….. YES NO
6. Do you have any other allergies……………………………………………YES NO
7. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?………………………………………………………….... YES NO
8. Are you sensitive to any metals or latex?……………………………….... YES NO
9. Do you have a pacemaker or artificial heart valve implant?…………….. YES NO
10. Have you ever had rheumatic fever?…………………………………….. YES NO
11. Are you aware of any heart murmurs?…………………………………… YES NO
12. Do you have high or low blood pressure?………………………………. YES NO
13. Have you ever had a serious illness or major surgery?…………………… YES NO
    If so, explain____
14. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?…………………………………………………………....... YES NO
15. Do you have inflammatory diseases, such as arthritis or rheumatism?........YES NO
16. Do you have any artificial joints / prosthesis?…………………………… YES NO
17. Do you have any blood disorders, such as anemia, leukemia, etc?……… YES NO
18. Have you ever bled excessively after being cut or injured?…………….... YES NO
19. Do you have any stomach problems?…………………………………… YES NO
20. Do you have any kidney problems?…………………………………….. YES NO
21. Do you have any liver problems?……………………………………….. YES NO
22. Are you diabetic? If so what type?……………………………………… YES NO
23. Do you have asthma?……………………………………………………YES NO
24. Do you have epilepsy or seizure disorders?…………………………….... YES NO
25. Are you pregnant or suspect you may be?... YES NO
26. Do you use any birth control medications? ……………………………… YES NO
27. Do you or have you had a venereal disease?……………………………. YES NO
28. Have you tested HIV positive?…………………………………………… YES NO
29. Do you have AIDS?……………………………………………………… YES NO
30. Have you had or do you test positive for hepatitis?…..A B or C……….. YES NO
31. Do you or have you had T.B?…………………………………………… YES NO
32. Do you smoke, chew, use snuff or any other form of tobacco?………… YES NO
33. Do you consume alcoholic beverages?………………………………….. YES NO
34. Have you had psychiatric treatment?…………………………………. YES NO
35. Do you have any disease, condition, or problem not listed?…………….. YES NO
    If so, explain ____
36. Is there anything else we should know about your health that we have not covered in this form? ____
37. What is the main reason for bringing your child to the dentist? _________________
    ____
    ____

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PARENT / GUARDIAN SIGNATURE____DATE______________