Children's Patient Information Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

Child's Name		Date of Birth ___/___/___	Social Security No.	M or F	Today's Date ___/___/___
Address		Home Phone (_____) _____-________		Cell Phone (_____) _____-________	
City,State,Zip		Referred by:			
Parent/Guardian's Name (Last, First, MI)	DOB ___/___/___	Social Security No.		Marital Status	
Parent/Guardian's Employer	Employer Address	Employer City/State/ZIP		Work Phone (_____) _____-________	
Name of parent whom child is insured under	Parent's DOB (Required) ___/___/___	Parent's Social Security No. (Required)		Phone (_____) _____-________	
Insured Parent's Employer	Employer Address	Employer City/State/ZIP		Work Phone (_____) _____-________	
Nearest friend not living with you	Address (Street/City/State/ZIP)			Phone (_____) _____-________	
Emergency Contact	Relationship			Phone (_____) _____-________	

Tell us how you would prefer to be contacted for your appointments? Please circle which you prefer: TEXT PHONE E-MAIL

Who is financially responsible for this bill?

How will the bill be paid today?

INSURANCE INFORMATION

Primary Insurance Name	Address (Street/City/State/ZIP)		Phone (_____) _____-________
Name of Insured Parent	DOB (Required) ___/___/___	Social Security No. (Required)	Group No. ID No.
Secondary Insurance Name	Address (Street/City/State/ZIP)		Phone (_____) _____-________
Name of Insured	DOB (Required) ___/___/___	Social Security No. (Required)	Group No. ID No.

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HEALTH HISTORY

Is your child in good health? _____Yes _____No Date of last physical exam ______________________________

Has there been any change in your child's health within the past year? _____Yes ____No

Is your child under the care of a physician? _____ For what condition? ______________________________

Name and address of your child's physician ______________________________

List any serious illness, operation, or hospitalization in the past 5 years. ______________________________

____

List all prescription and non-prescription medicine your child is currently taking. ______________________________

____

Check all of the following diseases or problems your child has experienced:

_____ Cardiovascular disease
_____ Sinus trouble
_____ Thyroid problem
_____ Persistent swollen glands in neck
_____ Allergies
_____ Asthma or hay fever
_____ Diabetes
_____ AIDS or HIV infection
_____ Sexually transmitted disease
_____ Tuberculosis
_____ Cancer
_____ Radiation to the head or neck area
_____Fainting spells/seizures
_____ Hepatitis, Jaundice, Liver disease
_____ Abnormal Bleeding
_____ Required a blood transfusion
_____ Blood disorder such as anemia
_____ Epilepsy/other neurological diseases
_____ Persistent cough/cough that produces blood
_____ Respiratory problems/emphysema/bronchitis
_____ Damaged/artificial heart valves
_____ Heart murmur/rheumatic heart disease
_____ History of rheumatic fever
_____ Artificial joints
_____ Arthritis/Painful swollen joints
_____ High blood pressure
_____ Gastric bypass

Is your child allergic to or has had a reaction to:

_____ Local anesthetics
_____ Sulfa Drug
_____ Aspirin
_____ Iodine
_____ Penicillin or other antibiotics
_____ Barbiturates, sedatives, sleeping
_____ Codeine or other narcotics
_____ Latex
_____Nuts
_____Other ____________________

Has your child had any serious trouble associated with previous dental treatments? ______________________________

____

Do you have any concerns about your child's teeth? ______________________________

____

For Adolescent Females:

Is your child pregnant? _____Yes _____No Is your child using prescribed birth control? _____Yes _____No

Parent/Guardian Signature______________________________