Children's Patient Information Form

Child's Name	Date of Birth ___/___/____	Social Security No.	M or F	Today's Date ___/___/____
Address		Home Phone (____) _____-_____	Cell Phone (____) _____-_____	
City/State/Zip				
Parent/Guardian's Name (Last, First, MI)	Date of Birth ___/___/____	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 (____) _____-_____	
Emergency Contact	Relationship		Phone (____) _____-_____	
How would you prefer to be contacted for your appointment: Please circle which you prefer: TEXT PHONE E-MAIL				
How would you prefer to receive your balance billing: Please circle which you prefer: TEXT MAIL E-MAIL Initial Here: _____				

Insurance Information

Primary Insurance Name:	Address (Street/City/State/Zip)	Phone (____) _____-_____	
Name of Insured:	Relationship:	I.D. No.	Group No.
Secondary Insurance Name:	Address (Street/City/State/Zip)	Phone (____) _____-_____	
Name of Insured:	Relationship:	I.D. No.	Group No.

CHILD HEALTH HISTORY

Date of last physical exam_____

Physician name and phone number_____

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

Has your child had any serious trouble associated with previous dental treatment or do you have concerns about their teeth?

_____

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

_____

List all prescriptions/non-prescription medicine_____

Do you require a **PREMED or antibiotic** before dental treatment (artificial joints or heart condition)

_____YES WHY_____ _____NO

CHECK ALL OF THE FOLLOWING DISEASES OR PROBLEMS YOUR CHILD HAS EXPERIENCED:

_____Allergies _____ Hay Fever _____ Aids/HIV

_____Abnormal Bleeding _____Artificial Joints When & what_____

_____Asthma _____Blood Transfusion _____ Cancer

_____Depression/Anxiety _____Diabetes _____Epilepsy

_____Heart Valve or Pacemaker _____Heart Murmur _____Heart Attack

_____Rheumatic Fever _____Kidney Problems _____Liver problems

_____Sexually transmitted diseases _____Thyroid problem _____ Sinus Trouble

Are they ALLERGIC to or had a reaction to:

_____Penicillin/Amoxicillin _____Other Antibiotics / Please list_____

_____Sulfa _____Aspirin _____Iodine

_____Codeine or other narcotics/Please List_____

_____Local Anesthetics _____Nuts/Peanut Butter _____Latex

For Adolescent Females:

Pregnant ____YES _____NO How many weeks?_____

Is your child using birth control? _____YES _____ NO

The answers I have given are true to the best of my knowledge. I am indicating my consent for my child's necessary dental treatment by signing here:_____