Child Patient History Form

Date _____

Child's Name_____ Nickname_____ Birthdate _____

Home Address_____ City_____ State _____ Zip _____

Home Phone _____ School _____ Grade _____

Father's Name _____ Employer _____ SSN _____

Employer's Address _____ Business Phone _____ Ext. _____

Mother's Name _____ Employer _____ SSN _____

Employer's Address _____ Business Phone _____ Ext. _____

Responsible Party's Name _____ Address _____ Phone _____

Dental Insurance Company _____ Carrier: Mother ____ Father ____ Other _____

Policy # _____ Group # _____ Certificate # _____ Name of Bank _____

Dental Information

Date of Last Dental Examination _____ Date of Last Full Mouth X-Rays _____

Reason for Visit _____

Referred By _____ Unfavorable Reaction to Medical and/or Dental Care _____

Medical Information

Name of Physician _____ Phone _____

Are You Under the Care of Physician Now? _____ If Yes, Explain _____

Date of Last Physical Examination _____

Past Medical History- Do you have or have you ever had (please answer yes or no):

Anemia _____
Asthma _____
Hayfever _____
Diabetes _____
Hepatits _____
High Blood Pressure _____
Abnormal Bleeding from a Cut _____
Emotional or Nervous Disorder _____

Allergies _____
To Penicillin _____
To Local Anesthetic _____
Other _____
Abnormal Heart Condition _____
Murmur _____
Pacemaker _____
Rheumatic Fever _____

Does Your Family Have A History of Any of The Above Disorders? _____

Are You Taking Any Medication _____ If So, What _____

Past Hospitalization _____

Past Illnesses _____

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made.
I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____