

**CHILD PATIENT INFORMATION**

**PATIENT HISTORY RECORD:**

***Child's Name:*** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home Phone #:** \_\_\_\_\_

**FAMILY RECORD:**

***Father's Name:*** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Business Phone #:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

***Mother's Name:*** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address (if different):** \_\_\_\_\_ **Cell Phone #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Business Phone #:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

Please list the first names of all brothers and sisters and their ages:

\_\_\_\_\_

**Person Responsible for Payment:** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Referred to our office by:** \_\_\_\_\_

Primary Dental Insurance Information	Secondary Dental Insurance Information
Insured's Name: _____	Insured's Name: _____
Insured's Birthdate: _____	Insured's Birthdate: _____
Employer Name: _____	Employer Name: _____
Insurance Company: _____	Insurance Company: _____
Insurance Address & Phone #: _____	Insurance Address & Phone #: _____
Policy #: _____ Insured's ID#: _____	Policy #: _____ Insured's ID#: _____

**Previous Dentist:** \_\_\_\_\_ **How long since last dental visit?** \_\_\_\_\_

*I hereby authorize Dr. Anderson and / or his associates to perform any and all treatment for my child and consent to such methods, drugs and agents as may be indicated in connection with his / her dental care. This consent shall remain in effect until cancelled.*

**Name:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_

**-Please Note-**

Payment is expected at time of service. If you provide your insurance form and proper information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

**SIGNATURE:** \_\_\_\_\_

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	N/A	
Are you under a physician's care now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

  

	Yes	No	N/A	
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Women: Are you (check if yes)  Pregnant / Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Other If yes, please explain: _____						

Do you have, or have you had, any of the following?

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint        | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No  N/A

Comments:

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\*Condition may require medication N/A - Not answered by patient

## **DENTAL HISTORY**

1. What is your primary dental concern? \_\_\_\_\_
2. How long since your last dental visit? \_\_\_\_\_
3. Your previous dentist's name: \_\_\_\_\_
4. Have you ever had any unusual problems or complications with previous dental treatment?  Yes  No  
If so, explain \_\_\_\_\_
5. Have you ever had any gum treatment or surgery?.....  Yes  No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_