

PATIENT NAME: _____ DATE OF BIRTH: _____ MALE FEMALE
 NAME CHILD GOES BY: _____ HOME PHONE: _____
 ADDRESS: _____ ZIP CODE: _____
 NAMES & AGES OF OTHER CHILDREN: _____
 FATHER'S NAME: _____ BUSINESS PHONE: _____
 EMPLOYER: _____ OCCUPATION: _____
 MOTHER'S NAME: _____ BUSINESS PHONE: _____
 EMPLOYER: _____ OCCUPATION: _____
 MARITAL STATUS OF PARENTS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED PARTNERED
 PARENT'S DENTIST: _____ CHILD'S PEDIATRICIAN: _____
 CHILD'S SCHOOL: _____ WHOM MAY WE THANK FOR
 REFERRING YOU TO OUR OFFICE?: _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE CHECK BOX.

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> DIABETES | <input type="checkbox"/> RESPIRATORY PROBLEM |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY / SEIZURES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GASTRIC REFLUX | <input type="checkbox"/> SINUS PROBLEM |
| <input type="checkbox"/> AUTISM | <input type="checkbox"/> HEART DISEASE OR ARRHYTHMIA | <input type="checkbox"/> STOMACH PROBLEM |
| <input type="checkbox"/> BEHAVIORAL DISORDER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PENICILLIN ALLERGY |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEMOPHILIA / BLEEDING DISORDER | <input type="checkbox"/> LATEX ALLERGY |
| <input type="checkbox"/> BONE DISORDER | <input type="checkbox"/> KIDNEY OR LIVER DISEASE | <input type="checkbox"/> OTHER ALLERGY:
_____ |
| <input type="checkbox"/> DEVELOPMENTAL DELAY | <input type="checkbox"/> PHYSICAL DISABILITY | <input type="checkbox"/> OTHER MEDICAL CONDITION:
_____ |

● IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN FOR OTHER THAN ROUTINE CARE? IF YES, PLEASE EXPLAIN:

● PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD IS TAKING AT THIS TIME:

● HAS YOUR CHILD HAD AN UNFAVORABLE DENTAL EXPERIENCE? IF YES, PLEASE EXPLAIN:

● DOES YOUR CHILD HAVE A HISTORY OF THUMBSUCKING, FINGERSUCKING, OR PACIFIER USE? IF YES, PLEASE CHECK BOX.

● DATE OF CHILD'S LAST DENTAL VISIT: _____

*The above information is true and correct to the best of my knowledge.
I agree to inform this office immediately of any changes in my child's medical status.*

Signature of Parent or Legal Guardian

Date