

## TELL US ABOUT YOUR CHILD

Preferred Name: Male Female School:	Child's Name:			Today's Date:			
Child's Home Address, City, State & Zip Code: Child's Special Interests/Activities: Do you have any other children who are seen in our office? If so, who? How did you hear about our office?  PARENT/LEGAL GUARDIAN'S INFORMATION  Parent's Marital Status:MarriedDivorcedSeparatedWidowedSingleRemarriedPartnered  If not mother/father, please state relationship (guardianship papers required):  Mother Name: Birthdate: SS#: E-Mail Address: Home Phone: Cell Phone: Work Phone: Employer:  Father Name: Birthdate: SS#: E-Mail Address: Home Phone: Cell Phone: Work Phone: E-Mail Address:  Address:  Home Phone: Cell Phone: Work Phone:  Employer:  INSURANCE INFORMATION:  Primary Insurance Insured's Name: Relationship to Patient: Insured's Birthday: Insured's ID: Employer  Employer's Address:  Insurance Co. Name: Phone #: Group #: Insurance Co. Address:	Preferred Name:	Male	Female	School:			
Child's Special Interests/Activities: Do you have any other children who are seen in our office? If so, who? How did you hear about our office?  PARENT/LEGAL GUARDIAN'S INFORMATION  Parent's Marital Status:MarriedDivorcedSeparatedWidowedSingleRemarriedPartnered  If not mother/father, please state relationship (guardianship papers required):  Mother Name:							
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How did you hear about our office?  PARENT/LEGAL GUARDIAN'S INFORMATION  Parent's Marital Status: _Married _Divorced _Separated _Widowed _ Single _ Remarried _Partnered  If not mother/father, please state relationship (guardianship papers required):  Mother Name: Birthdate: SS#: E-Mail Address: Home Phone: Cell Phone: Work Phone: Employer:  Father Name: Birthdate: SS#: E-Mail Address: Home Phone: Cell Phone: Work Phone:  INSURANCE INFORMATION:  Primary Insurance Insured's Name: Relationship to Patient: Insured's Birthday: Insured's ID: Employer  Insurance Co. Name: Phone #: Group #:	Child's Special Interests/A	ctivities:					
PARENT/LEGAL GUARDIAN'S INFORMATION  Parent's Marital Status:MarriedDivorcedSeparatedWidowedSingleRemarriedPartnered  If not mother/father, please state relationship (guardianship papers required):  Mother Name: Birthdate:  SS#: E-Mail Address:  Home Phone: Cell Phone: Work Phone:  Employer:  Father Name: Birthdate:  SS#: E-Mail Address:  Home Phone: Cell Phone:	Do you have any other chi	ldren who are seen in our off	fice? If so, who?_				
Parent's Marital Status: _Married _Divorced _Separated _Widowed _Single _Remarried _Partnered  If not mother/father, please state relationship (guardianship papers required):  Mother Name:	How did you hear about or	ır office?					
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Employer:	Address:						
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Employer's Address:	Employer's Address:			1			
Employer's Address:	Insurance Co. Name:	Pho	one #:	Group #:			
Insurance Co. Address:	Insurance Co. Address:	<b>1</b> 110					
We confirm appointments via text and email.	We confirm appointments	via text and email.					
Cell Phone: Email Address:	Cell Phone:	Fmail Addrass					

## MEDICAL HISTORY

Patient Name:			Birthdate:	Gender: 🛭 Female	□ Male
hat is the main reason you brought your child to us to	ndav3				
ho is/are your child's physician(s)? List:					
your child taking any medicines, vitamins, or supplement	ents2	V / N	l list:		
is your child had any surgeries? Y/N List:	Citio	, , ,			
your child ALLERGIC to any medicines? Y / N List:					
your child ALLERGIC to any materials or foods? Y /					
,					
Has your child EVER HAD any of the following			<b>T</b>		
conditions?	У	N	If yes, please explain:		
Heart disease (including heart murmur)					
Lung or breathing problems (e.g. asthma, reactive					
airway, sleep apnea/snoring, cystic fibrosis)					
Frequent exposure to tobacco smoke					
Diabetes, hyperglycemia, hypoglycemia					
Thyroid or other hormonal problems					
Intestinal or digestion problems (including acid reflux					
or GERD)  Jaundice, hepatitis, or liver problems	+				
Kidney or bladder problems					
Joint, muscle, bone problems					
Rash/hives, eczema, or skin problems					
Anemia, hemophilia, bruises easily, or excessive					
bleeding	-				
Sickle cell disease or trait					
Transfusions or received blood products					
Cancer, tumor, other malignancy, chemotherapy,					
radiation therapy, bone marrow transplant					
Frequent infections / serious infections (e.g. MRSA,					
TB)					
Sexually transmitted disease or HIV					
Speech, hearing, or eye problems					
Frequent headaches					
Epilepsy or convulsions/seizures					
Cerebral palsy or other neurological disease					
Premature birth or complications with birth					
Inherited (genetic) condition or syndrome					
Developmental disorders or delays (including mental or					
physical)	1				
Behavior, emotional, or psychiatric problems (e.g.					
ADD/ADHD, Autism, or other conditions) Eating disorders	+				
Abuse (physical, psychological, emotional, or sexual)					
Neglect					
Es there any other problem or medical condition that we should know about in order to care for your child?					
,  NT/GUARDIAN SIGNATURE: To the best of my knowledge, the que een accurately answered. I understand that providing incorrect inform				have consulted with the parent, guardian, and/or dates to the medical history.	physician of pat
child's health. It is my responsibility to inform the dental office of any				·	
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			Printed Name	/////	_/2017_ Date
ted Name Signature	Date			- y	