my pediatric dentist
BAYLISS PARK

TELL US ABOUT YOUR CHILD

Child's Name: _____ Today's Date: _____
Preferred Name: _____ Male ____ Female _____ School: _____
Child's Birthdate: _____ Child's Age: _____ Child's SS#: _____
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: __Married __Divorced __Separated __Widowed __ Single __ Remarried __Partnered

If not mother/father, please state relationship (guardianship papers required): _____

Mother Name: _____ Birthdate: _____
SS#: _____ E-Mail Address: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____

Father Name: _____ Birthdate: _____
SS#: _____ 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: _____

- ***Secondary 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: _____

We confirm appointments via text and email.

Cell Phone:_____ Email Address: _____

MEDICAL HISTORY

Patient Name:_____ Birthdate:_____ Gender: □ Female □ Male

What is the main reason you brought your child to us today? _____
Who is/are your child's physician(s)? List: _____
Is your child taking any medicines, vitamins, or supplements? Y / N List: _____
Has your child had any surgeries? Y / N List: _____
Is your child ALLERGIC to any medicines? Y / N List: _____
Is your child ALLERGIC to any materials or foods? Y / N List: _____

Has your child EVER HAD any of the following conditions?	**Y**	**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)			
Behavior, emotional, or psychiatric problems (e.g. ADD/ADHD, Autism, or other conditions)			
Eating disorders			
Abuse (physical, psychological, emotional, or sexual)			
Neglect			
Is there any other problem or medical condition that we should know about in order to care for your child?			

PARENT/GUARDIAN SIGNATURE: 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 child's health. It is my responsibility to inform the dental office of any changes in medical status.

_____
Printed Name Signature Date

DENTIST SIGNATURE: I have consulted with the parent, guardian, and/or physician of patient and have made any necessary updates to the medical history.

_____ _____ /____/2017_
Printed Name Signature Date