my pediatric dentist
BAYLISS PARK | BELLEVUE

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.

RYAN T. HAJEK_______________________________ __/___/2017_
Printed Name Signature Date