

Date: _____

PATIENT INFORMATION

Patient name: _____	D.O.B _____	Male / Female
Insured Parent SS #: _____	Primary Email Address: _____	
Home Address: _____		City: _____
State: _____	Zip Code: _____	Primary phone: _____

PATIENT HEALTH HISTORY

Date of last dental visit: _____ Reason for visit: _____

Has the patient ever had **ANY** of the following? (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney/Liver disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Lyme's Disease/Meningitis |
| <input type="checkbox"/> Autism/ the Autism Spectrum | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malignant Hyperthermia |
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Mental or Nervous disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Fevers | <input type="checkbox"/> MRSA/Any Infectious Diseases |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma/Eye Disorders | <input type="checkbox"/> Respiratory problems/RSV |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever/Rheumatism |
| <input type="checkbox"/> Blisters in the mouth | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Blood diseases | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer or Chemo | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other: _____ |

Medications Taken: (List all that apply) _____ Medication Allergies _____

Has the patient ever had any complications following dental treatment? YES / NO

If yes, please explain: _____

Has the patient ever been admitted to a hospital or required emergency care? YES / NO

If yes, please explain: _____

Is the patient under the care of a medical physician YES / NO Last Visit: _____

If yes, please explain: _____

Name of patient's medical doctor: _____ Phone #: _____

To the best of my knowledge, all the answers and information are true and correct. If there is any change in the patient's medical history, I will inform the office staff and the dentist at the next appointment. IF you have any changes with your Insurance plan, please call the office in advance to discuss your benefits and give the office new dental insurance information.

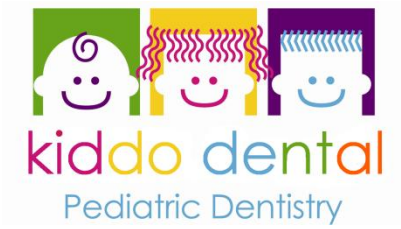
Signature of parent, guardian or patient if over 18

Date

Initials _____ I, hereby, give consent for my child to have an exam, a teeth cleaning, a fluoride treatment, and any or all necessary X-rays for diagnosis of treatment or/for preventative measures as set by AAPD guidelines.

X-rays are sole property of Kiddo Dental.

(Consent shall remain in effect unless otherwise stated or revoked by parent or legal guardian)



PARENTS / GUARDIAN / RESPONSIBLE PARTY INFORMATION

Parent (Mother): _____ D.O.B: _____ Married / Single / Divorced
 Social security#: _____ Email: _____
 Mailing Address (if different from patient) _____ APT# _____
 City: _____ State: _____ Zip code: _____
 Home phone: _____ Cell: _____ Work#: _____ Ext: _____
 Employer: _____ Occupation: _____

Parent (Father): _____ D.O.B: _____ Married / Single / Divorced
 Social security#: _____ Email: _____
 Mailing Address (if different from patient) _____ APT# _____
 City: _____ State: _____ Zip code: _____
 Home phone: _____ Cell: _____ Work#: _____ Ext: _____
 Employer: _____ Occupation: _____

Dental Insurance YES / NO

INSURANCE INFORMATION

Name of Insurance: _____ Phone # _____
 Subscriber name: _____ D.O.B: _____
 Social Security #: _____ Member ID# _____
 Group # _____ Group plan name or employer: _____

REFERRAL INFORMATION

Whom may we thank for referring you to Kiddo Dental?
 Another patient: _____ Another Office: _____
 Other: _____ Internet website: _____
 Our website/drove by/ yellow pages

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any changes in the patient's health, I (Parent/guardian) will update the patient's medical history at the next appointment.

 Signature of Parent/Guardian/Responsible Party

 Date