

## Child Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Preferred Contact Phone# \_\_\_\_\_ cell / home / work

Address: \_\_\_\_\_

Street

City

State

Zip Code

\_\_\_ Male \_\_\_ Female

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's SSN: \_\_\_\_\_ Father's SSN: \_\_\_\_\_

**Has Insurance Changed** (circle one) YES / NO (If yes, explain) \_\_\_\_\_

**Future Billing Statements** (circle one) Email / Text / Mail

**Who is financially responsible for this child/patient?** \_\_\_\_\_

### Health History Please check those that apply

\_\_\_ AIDS/HIV Infection

\_\_\_ Acid Reflux

\_\_\_ Allergies: Type: \_\_\_\_\_

\_\_\_ Anemia

\_\_\_ Anxiety/Mental Disorder/Depression

\_\_\_ Artificial Joints: Date: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Asthma

\_\_\_ Autoimmune Disease: Type: \_\_\_\_\_

\_\_\_ Blood Disorder

\_\_\_ Cataracts/ Glaucoma

\_\_\_ Cancer: When: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Cholesterol

\_\_\_ Cold Sores

\_\_\_ Diabetes

\_\_\_ Dizziness/ Fainting

\_\_\_ Epilepsy

\_\_\_ Excessive Bleeding

\_\_\_ Headaches/ Head Injury

\_\_\_ Herpes: Type \_\_\_\_\_

\_\_\_ Heart Murmur/ Mitral Valve Prolapse

\_\_\_ Heart Problems: Type: \_\_\_\_\_

\_\_\_ Hepatitis: Type: \_\_\_\_\_

\_\_\_ High Blood Pressure

\_\_\_ Kidney Disease

\_\_\_ Liver Disease/ Jaundice

\_\_\_ Organ Transplant: When: \_\_\_\_\_ Type: \_\_\_\_\_

\_\_\_ Premedicate w/ antibiotics

\_\_\_ Penicillin Allergy

\_\_\_ Pacemaker

\_\_\_ Radiation Treatment

\_\_\_ Respiratory Problems

\_\_\_ Sinus Problems

\_\_\_ Stomach Problems

\_\_\_ TOBACCO Use

\_\_\_ Thyroid Disorder

\_\_\_ Tuberculosis

\_\_\_ Ulcers

**\* COVID 19 FULLY VACCINATED YES / NO**

**Are you allergic to latex?** YES / NO

**Are you currently taking blood thinners?** YES / NO

Describe any other health problems not listed above: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Have you ever had any complications following past dental treatments? YES / NO

If yes, Explain: \_\_\_\_\_

Medical Physician : \_\_\_\_\_ Phone: \_\_\_\_\_

I have reviewed and accept the terms of the Privacy Act (HIPAA)

**Signature of**  
**parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_