CHILD/TEEN

Name _____ Date of Birth _____

Nickname or preferred name _____ Home/Cell Phone _____

E-Mail address_____ City & Zip code _____

Street address_____ Father's Date of Birth _____

Father's Name _____ Father's Work Phone_____

Father's Social Security Number _____ Father's Dental Plan_____

Father's Employer_____ Mother's Date of Birth _____

Mother's Name__ _____ Mother's Work Phone _____

Mother's Employer _____ Mother's Dental Plan _____

Mother's Social Security Number _____

Who can we thank for telling you about our office? _____

Does the child have or has he/she had any of the following?

YES	NO	YES	NO	YES	NO
___	___ **Latex reaction**	___	___ **Allergy to Anesthetics**	___	___ Cancerous/Noncancerous growth
___	___ **Heart Murmur**	___	___ Developmentallydisabled	___	___ Radiation treatment
___	___ **Rheumatic Fever**	___	___ Diabetes	___	___ Chemotherapy
___	___ **Artificial Heart Valve**	___	___ Hypoglycemia	___	___ Anemia
___	___ **Artificial Joint or Bone**	___	___ Thyroid Disorder	___	___ Acid Reflux/Gird
	Replacement	___	___ Kidney Disorder	___	___ Seizures, Fainting, Epilepsy
___	___ **Heart Surgery**	___	___ Hepatitis – If yes,	___	___ Asthma, Emphysema
___	___ **Mitral Valve Prolapse**		what type?	___	___ Tuberculosis
___	___ **Current Pregnancy**		___ A	___	___ Ulcer
___	___ **Any heart disease**		___ B	___	___ Bladder Problem
___	___ Organ Transplant		___ C	___	___ Stent (heart/neurological)
___	___ High Blood Pressure	___	___ Jaundice/Liver Disorders	___	___ Hearing Problem
___	___ Low Blood Pressure	___	___ Glaucoma	___	___ **HIV positive**
___	___ Circulatory Problems	___	___ Arthritis, Physical Disability	___	___ Respiratory Diseases
___	___ Stroke	___	___ Nervous Problems	___	___ Blood Transfusions
___	___ Phlebitis	___	___ Psychiatric Care	___	___ Blood Disorder
___	___ **Abnormal Bleeding**	___	___ Frequent Headaches	___	___ Persistent cough with
	(Hemophilia)	___	___ Sinus Problems		phlegm or blood
___	___ Home drinking water is well water				

Please list anything your child has been diagnosed with that is not listed above and/or any medications the child is taking and reasons for taking :

_____

Please list any allergies, especially to medication _____

The child has been hospitalized for _____

Name of family physician _____

Current dental concerns _____

Signature of parent or guardian _____ Date _____