Welcome To North Deering Dental Associates, P.A.

Confidential Patient Medical History-Child

Date:____________

Patients Name:__________________________Nickname:____________________
DOB:_______SSN:________________Home #:__________Work #:__________
Home Address:____
If patient is a student please provide name of School/College:____________________
Is your child covered by dental insurance YES______ NO______

If YES:

Name as it appears on the insurance card:____________________________
D.O.B. of subscriber:____
SSN of subscriber:____
Employer's Name and Address:_____________________________________
____
Work Phone #:________________
Name of Insurance:________________________Group #:_______________
Address of Insurance Company:_____________________________________
____

If NO:

Name of person responsible for this account:__________________________

Billing Address:____
____

Signature of Parent or Guardian:______________________________Date:________

OVER

CHIID PATIENT MEDICAL HISTORY (continued)

Physician_____________ Office Phone_____________ Date of Last Exam_______

	Yes	No	If yes please explain
Is this your child's first dental visit?	___	___	____________________________
Is your child under medical treatment now?	___	___	____________________________
Has your child ever had any surgeries?	___	___	____________________________
Has your child ever been hospitalized?	___	___	____________________________
Does your child take any medications?	___	___	____________________________
Does your child have any allergies?	___	___	____________________________
Is your child allergic to any medications? (including novocaine, antibiotics, ect.)	___	___	____________________________
Permission for fluoride and x-rays?	___	___	

Has your child have or had any of the following?

Yes	No		If YES please explain
___	___	High Blood Pressure	__________________
___	___	Rheumatic Fever	__________________
___	___	Heart Disease	__________________
___	___	Heart Murmur	__________________
___	___	Prosthetic Surgery	__________________
___	___	Hepatitis	__________________
___	___	Jaundice	__________________
___	___	Diabetes	__________________
___	___	Epilepsy	__________________
___	___	Allergies	__________________
___	___	Tuberculosis	__________________
___	___	AIDS or HIV	__________________
___	___	Anemia	__________________
___	___	Asthma	__________________
___	___	Sinus Trouble	__________________
___	___	Chest Pain	__________________
___	___	High Blood Pressure	__________________
___	___	Low Blood Pressure	__________________
___	___	Psychiatric Disorders	__________________
___	___	Cancer or Tumors	__________________
___	___	Blood Disorders	__________________
___	___	Cold Sores	__________________
___	___	Latex Allergy	__________________
___	___	Fainting/Seizures	__________________
___	___	Stomach Trouble	__________________
___	___	OTHER	__________________

Signature:____ Date:_____________

(parent or guardian)