pediatric

PATIENT INFORMATION & HEALTH HISTORY

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DDS • MS

PLEASE PRINT

Date.....

PATIENT INFORMATION

NAME..... SS#.....
LAST FIRST MIDDLE LIKES TO BE CALLED

ADDRESS..... CITY..... STATE..... ZIP.....

DATE OF BIRTH..... AGE..... ❑ MALE ❑ FEMALE CELL PHONE..... HOME PHONE.....

SCHOOL..... GRADE..... SPORTS / INTERESTS..... EMAIL.....

PATIENT LIVES WITH: ❑ BOTH PARENTS ❑ MOTHER ❑ FATHER ❑ GUARDIAN REFERRED BY.....

DENTIST..... PHYSICIAN..... MAIN CONCERN.....

RESPONSIBLE PARTY INFORMATION

NAME..... ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED
LAST FIRST MIDDLE

ADDRESS..... CITY..... STATE..... ZIP.....

HOW LONG AT THIS ADDRESS?..... HOME PHONE..... WORK PHONE..... EMAIL.....

SOCIAL SECURITY #..... DRIVER'S LICENSE #..... DATE OF BIRTH.....

EMPLOYER..... OCCUPATION..... HOW LONG EMPLOYED.....

SPOUSE'S NAME.....
LAST FIRST MIDDLE

SOCIAL SECURITY #..... DRIVER'S LICENSE #..... DATE OF BIRTH.....

SPOUSE'S EMPLOYER..... OCCUPATION..... WORK PHONE.....

INSURANCE INFORMATION

INSURED'S NAME..... INSURED'S SOCIAL SECURITY #.....

INSURANCE COMPANY..... GROUP #.....

INSURANCE CO. ADDRESS..... PHONE #.....

DO YOU HAVE DUAL COVERAGE? ❑ YES ❑ NO If yes, please fill in below:

INSURED'S NAME..... INSURED'S SOCIAL SECURITY #.....

INSURANCE COMPANY..... GROUP #.....

INSURANCE CO. ADDRESS..... PHONE #.....

CONTACT INFORMATION

PHONE Home..... Work..... Cell..... EMAIL.....

BEST TIME AND PLACE TO CONTACT YOU.....

IN CASE OF EMERGENCY, PLEASE CONTACT: (Specify someone who does NOT live in your household.)

NAME..... RELATIONSHIP.....

PHONE Home..... Work..... Cell..... EMAIL.....

MEDICAL HISTORY

HAS THE PATIENT EVER HAD:

DIABETES	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO	ENDOCRINE/THYROID	☐ YES ☐ NO
KIDNEY TROUBLE	☐ YES ☐ NO	ANEMIA	☐ YES ☐ NO	PROLONGED BLEEDING	☐ YES ☐ NO
PNEUMONIA	☐ YES ☐ NO	EPILEPSY	☐ YES ☐ NO	HEPATITIS	☐ YES ☐ NO
HEART TROUBLE	☐ YES ☐ NO	ASTHMA	☐ YES ☐ NO	FAINTING/DIZZINESS	☐ YES ☐ NO
RHEUMATIC FEVER	☐ YES ☐ NO	ARTHRITIC CONDITION	☐ YES ☐ NO	CANCER	☐ YES ☐ NO

Do you have any other medical concerns? ☐ YES ☐ NO Explain.....

Is the patient currently taking any drug or medications? ☐ YES ☐ NO Please list.....

Does the patient use tobacco products? ☐ YES ☐ NO What type?.....

Does the patient use any controlled substances? ☐ YES ☐ NO Please list.....

Is the patient allergic to any of the following? ☐ Acrylic ☐ Nickel ☐ Latex ☐ Medications ☐ Pollens ☐ Other.....

Has the patient tested POSITIVE for HIV/AIDS? ☐ YES ☐ NO

Does the patient wear contact lenses? ☐ YES ☐ NO

Have patient's tonsils and adenoids been removed? ☐ YES ☐ NO At what age?.....

Does the patient snore? ☐ YES ☐ NO

Does the patient have any congenital (born with) abnormalities?.....

Growth in the last six months:..... Has patient reached puberty? ☐ YES ☐ NO

Height: Patient..... Mother..... Father..... Patient most resembles: ☐ MOTHER ☐ FATHER ☐ BOTH

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? ☐ YES ☐ NO Explain.....

Did the patient ever suck thumb, fingers, pacifier? ☐ YES ☐ NO Until what age?.....

Does the patient have any problems with speech? ☐ YES ☐ NO Explain.....

Does the patient play a musical instrument? ☐ YES ☐ NO What type?.....

Has the patient been informed of any missing/extra permanent teeth? ☐ YES ☐ NO

Has the patient had previous orthodontic examinations or treatment? ☐ YES ☐ NO

Is the patient especially apprehensive about dental visits? ☐ YES ☐ NO

Does the patient want orthodontic treatment? ☐ YES ☐ NO

When did you last visit the general dentist?..... Is any dental work pending?.....

TMJ HISTORY

Has the patient ever had any discomfort or clicking in the jaw-joint near the ears? ☐ YES ☐ NO

Does the patient clench or grind his/her teeth? ☐ YES ☐ NO

Does the patient have frequent head or neck aches? ☐ YES ☐ NO

Does the patient have pain or ringing in the ears? ☐ YES ☐ NO

Has the patient's jaw ever locked or slipped out of place? ☐ YES ☐ NO

Are the patient's teeth sore or sensitive? ☐ YES ☐ NO

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 (or patient's) health. It is my responsibility to inform Dr. Miller of any changes in medical status.

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Signature of Patient, Parent, or Guardian

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Date