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PATIENT INFORMATION FORM

CHILD'S NAME____ AGE _______ SEX ________

CHILD'S NICKNAME_______________________ BIRTHDAY________________SOCIAL SECURITY # ____________________

ADDRESS_____________________________________ CITY____________________STATE______ZIP ____________

PARENT OR GUARDIAN__________________________________RELATIONSHIP TO PATIENT ____________________

DATE OF BIRTH_________________________________ SOCIAL SECURITY ______________________________

HOME PHONE_____________________CELL PHONE_____________________WORK PHONE ____________________

EMAIL__________________________________ PLACE OF EMPLOYEMENT ______________________________

DENTAL INSURANCE: YES______ NO______ INSURANCE COMPANY ________________________________

NAME OF INSURED_______________________________ INSURED'S EMPLOYER ___________________________

INSURED'S BIRTHDATE_____________________________ INSURED'S ID# ________________________________
(MAY BE SOCIAL SECURITY NUMBER)

Who should we thank for referring you? ____

PAST MEDICAL HISTORY

Is your child seeing a doctor (Physician/MD/Osteopath/Chiropractor) for any reason? ☐ No ☐ Yes If so, please explain ____________________

____

Has your child ever been in the hospital? ☐ No ☐ Yes If so, please explain ______________________________________

____

Has your child ever had an operation? ☐ No ☐ Yes If so, please explain ______________________________________

____

Has your child ever had a serious illness or injury? ☐ No ☐ Yes If so, please explain ______________________________

____

Has your child ever had a blood transfusion? ☐ No ☐ Yes If so, when ____

____

Is your child allergic to any medicines, dust, pollens, etc.? ☐ No ☐ Yes If so, please explain ___________________________

____

Is your child taking any medication? ☐ No ☐ Yes If so, please explain ____

____

CONTINUED ON BACK

Has your child had any of the following illnesses and/or conditions?

Heart Disease	☐ No	☐ Yes	________
Rheumatic Fever	☐ No	☐ Yes	________
Heart Murmur	☐ No	☐ Yes	________
High Blood Pressure	☐ No	☐ Yes	________
Respiratory Disease	☐ No	☐ Yes	________
Asthma	☐ No	☐ Yes	________
Tuberculosis	☐ No	☐ Yes	________
Wheezing	☐ No	☐ Yes	________
Hepatitis	☐ No	☐ Yes	________
Jaundice	☐ No	☐ Yes	________
Diabetes	☐ No	☐ Yes	________
Thyroid Problems	☐ No	☐ Yes	________
Kidney Infections	☐ No	☐ Yes	________
Kidney Disease	☐ No	☐ Yes	________
HIV	☐ No	☐ Yes	________
Sickle Cell Disease	☐ No	☐ Yes	________
Anemia	☐ No	☐ Yes	________
Bleeding Disorder	☐ No	☐ Yes	________
Leukemia	☐ No	☐ Yes	________
Seizures	☐ No	☐ Yes	________
Allergies	☐ No	☐ Yes	________
Handicaps	☐ No	☐ Yes	________
Birth Defects	☐ No	☐ Yes	________
Syndromes (Down's, etc.)	☐ No	☐ Yes	________
Mental Retardation	☐ No	☐ Yes	________
Learning Disability	☐ No	☐ Yes	________
Autism	☐ No	☐ Yes	________
Speech or pronunciation problems	☐ No	☐ Yes	________
Hearing Impairment	☐ No	☐ Yes	________

Who is your child's medical doctor?

Name ____

Address ____

Because this patient is a minor it is necessary for us to have consent of the child's parent or legal guardian prior to rendering dental services. Therefore, your signature below authorizes Dr. Flowers or Dr. Crowder and their staff to collect the necessary diagnostic and study information, and to provide whatever dental treatment, medicines and therapy that may be indicated for this child in Dr. Flowers' or Dr. Crowder's best judgement.

Signature________________________________Date ______________

Relation ____

This consent shall remain in effect until cancelled by either party.

All treatment plans and services rendered will be discussed with the parent prior to beginning treatment.

Payment due when services are rendered.