Welcome!

PATIENT INFORMATION Date: _____

Name: _____

Birth Date: _____ Age: _____ Sex: _____

Address: _____ City: _____

State: _____ Zip: _____

RESPONSIBLE PARTY

Name of Person Responsible for the Patient: _____

Relationship to Patient: _____ Driver's License #: _____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Employer: _____ Social Security Number: _____

Insurance Co: _____ Plan Number: _____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y	N	Allergies to any drugs	Y	N	Diabetes
Y	N	Any Hospital Stays	Y	N	Seizures/Epilepsy
Y	N	Any Operations	Y	N	Handicaps/Disabilities
Y	N	Heart Defects	Y	N	Cerebral Palsy
Y	N	Asthma/Lung Problems	Y	N	Developmental Delays
Y	N	Hepatitis/Liver Problems	Y	N	Rheumatic/Scarlet Fever
Y	N	Kidney Problems	Y	N	Cancer
Y	N	Bleeding/Blood Problems	Y	N	Autism Spectrum Disorder
Y	N	Heart Murmurs	Y	N	Tuberculosis
Y	N	Down Syndrome	Y	N	ADHD

Please discuss any medical problems that the child has/had: _____

_____

_____

Has your child ever been diagnosed with a Syndrome? Y N If yes, please explain: _____

_____

Child's Physician: _____ Phone Number: _____

Is the child currently under the care of a physician: Yes No Date of last visit: _____

Please describe the child's current physical health: Excellent ____ Good ____ Poor ____

Please list all medications the child is currently taking: _____

_____

Please list all allergies the child has, including medications: _____

_____

What is your child's favorite character/toy/movie: _____

_____

Who can we thank for referring you to our office: _____

What is the best way to contact you: (please check all that apply)

_____ home phone _____ cell phone _____ e-mail _____ text message

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and is my responsibility to inform the doctors at Encino Pediatric Dental Group of any changes in my child's medical status at the earliest possible time.

_____ _____

Signature Print Name

_____ _____

Doctor Signature Date

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