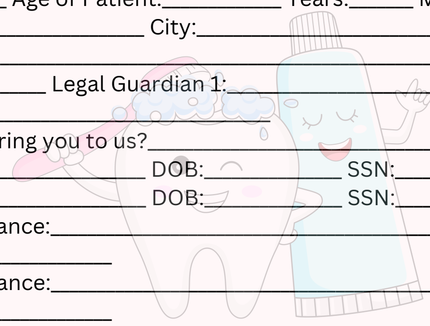
Patient Information Form

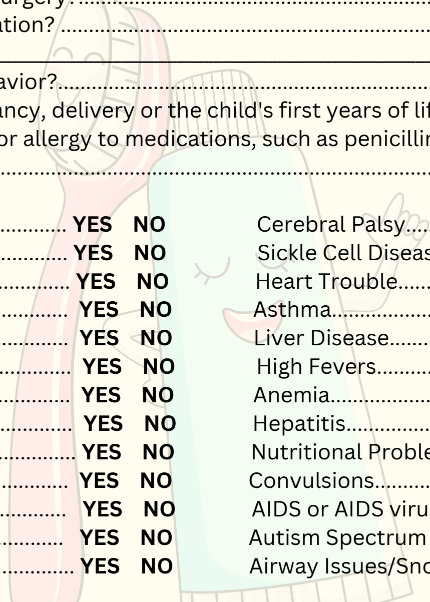
Please complete this form as accurately as possible.This will help us provide the best possible health service for you and your child. This information form becomes part of our permanent records and will be held in strict confidence. If you are unable to complete this form by yourself, please ask for assistance. Thank you

Personal



Patient's Name:______________________________ Nickname:____________________
Date of Birth:__________ Age of Patient:_______ Years:____ Months:____ Sex: Male ( ) Female ( )
Home Address:__________________ City:______________ State:______ Zip Code:________
Name of School:____
Telephone: Home:__________ Legal Guardian 1:______________ Legal Guardian 2:__________
Email:____________________________
Whom may we thank for referring you to us?______________________________
Legal Guardian 1:________________ DOB:________ SSN:_________ Occupation:________
Legal Guardian 2:________________ DOB:________ SSN:_________ Occupation:________
Legal Guardian 1 Dental Insurance:_______________________ ID #:_________ Group #:_____
Employer Name:______________
Legal Guardian 2 Dental Insurance:_______________________ ID #:_________ Group #:_____
Employer Name:______________
Sibling's Names & Ages:____
Primary Doctor's Name:___________________________ Phone:_____________________

Dental & Medical History



1.) Has the patient had any unusual or unpleasant experiences in a dental or medical office?.................... YES NO
2.) Has the patient had any injuries to the face, mouth or teeth?.................... YES NO
3.) What is the chief concern regarding the patient's oral health? ______________________
4.)Has the child been in a hospital or had surgery?.................... YES NO
5.) Is the Child currently taking any medication? .... YES NO
If yes, what?______________________________
6.) Does the Child have any abnormal behavior?.................... YES NO
7.) Were there any problems during pregnancy, delivery or the child's first years of life? .... YES NO
8.)Has the child had any unusual reaction or allergy to medications, such as penicillin, aspirin, or local anesthetics?.................... YES NO
9.) Does the Child have any history of:

Condition			Condition		
Excessive or Prolonged Bleeding............	YES	NO	Cerebral Palsy............................	YES	NO
High Blood Pressure................................	YES	NO	Sickle Cell Disease........................	YES	NO
Kidney Disease..	YES	NO	Heart Trouble................................	YES	NO
Diabetes..	YES	NO	Asthma..	YES	NO
Tuberculosis	YES	NO	Liver Disease................................	YES	NO
Behavior Problems....................................	YES	NO	High Fevers..................................	YES	NO
Cancer or Tumors......................................	YES	NO	Anemia..	YES	NO
Speech Problems.......................................	YES	NO	Hepatitis..	YES	NO
Hearing Problems......................................	YES	NO	Nutritional Problems..................	YES	NO
Birth Defects...	YES	NO	Convulsions..................................	YES	NO
Heart Murmur..	YES	NO	AIDS or AIDS virus carrier..........	YES	NO
X-RAY Treatment.......................................	YES	NO	Autism Spectrum Disorder.........	YES	NO
Unlisted Condition.....................................	YES	NO	Airway Issues/Snoring................	YES	NO

If yes, explain? ______________________________

10.)Please describe any current medical treatment, including drugs, pending surgery, recent injuries or any other information the doctor should be aware of:
11.) Does your child use a mouthguard for sports?........................... YES NO
12.) Child's interests, hobbies or pets: ____.
13.) If there is any other information that you believe would be helpful to us, please comment:

Consent for Treatment

I, being the (father) (mother) (guardian) of the above named child, hereby give consent to Children's Dental. & Orthodontic Associates to perform the dental treatment necessary to correct oral problems present as well as express consent to utilize the behavior management techniques approved and recommended by the American Academy of Pediatric Dentistry, (i.e., Tell, Show, Do Behavior Modification). I will inform Children's Dental & Orthodontic Associates of any new medical problems or changes that may occur in the future.
You also give us permission to use your signature on file for your insurance forms.

Signature:________________________________ **Date:**________________

LOCATIONS:

7847 Old York Road
Elkins Park, PA 19027
215-635-5560

607 Chestnut Street
Philadelphia, PA 19106
215-925-6251

Dr. Scott Solow
Dr. Alex Rosner