

Date _____

FAMILY INFORMATION SHEET

Patient Information

Patient's Last, First Name _____ Nickname _____
 Patient's Address _____ City _____ Zip _____
 Sex ____ Patient's Birthdate _____ Age ____ Was patient adopted? Y or N
 Patient's school he/she is attending _____
 List other children in your family: _____
 Father's First & Last Name _____ Phone () _____ Cell () _____
 Address (if different than above) _____
 Mother's First & Last Name _____ Phone () _____ Cell () _____
 Address (if different than above) _____

Parent Information

Father:
 Birthdate _____ S.S.# _____ Occupation _____
 Employer _____ Work # () _____ Address _____
 Dental Insurance _____ Address _____
 Insurance phone Number () _____ Group # _____ Primary or Secondary (please circle)
Mother:
 Birthdate _____ S.S. # _____ Occupation _____
 Employer _____ Work # () _____ Address _____
 Dental Insurance _____ Address _____
 Insurance Phone Number () _____ Group # _____ Primary or Secondary (please circle)
 Person financially responsible for account _____
 ** **Mastercard/Visa, American Express, Cash, Check and Insurance are accepted for payment on your account** **

Confirming Appointments: (Our goal is to verbally confirm each appointment in order to effectively accommodate our patients and appointments needed. If you need to cancel, please contact our office at least 24 hours prior to appointment)

1. Would it be ok to call Mom at work and/or Dad at work? Yes or No. If yes, Mom Dad Either
2. Would you like your appointment confirmed via email or phone (please circle)? If email, address _____

Dental Information

What is the purpose of this dental visit? _____
 Are there any x-rays from another office? _____ Previous Dentist: _____
 Who referred you to our office? _____ We would like to thank our friends for supporting us.

Medical Information

Child's Medical Physician _____ Phone () _____

Has child had any history of the following:

Allergies, List _____ Y__ N__	Epilepsy Y__ N__
HIV positive Y__ N__	Convulsions..... Y__ N__
Blood Disorders..... Y__ N__	Cerebral Palsy..... Y__ N__
Anemia..... Y__ N__	Down Syndrome Y__ N__
Excessive Bleeding Y__ N__	Emotional Problem Y__ N__
Leukemia Y__ N__	Learning Disability Y__ N__
Cancer Y__ N__	Attention Def. Dis and /or ADHD Y__ N__
Hepatitis Y__ N__	Speech Impediment Y__ N__
Liver Disease Y__ N__	Hearing Problem Y__ N__
High Blood Pressure Y__ N__	Diabetes Y__ N__
Rheumatic Fever Y__ N__	Skin Problem Y__ N__
Heart Problem Y__ N__	Tuberculosis Y__ N__
Asthma Y__ N__	Tumors Y__ N__
Kidney Disease Y__ N__	Diagnostic Testing Y__ N__
Medications, _____ Y__ N__	Shunts, type? _____ Y__ N__
Other _____	Autism/Asperger's Y__ N__

Signature _____ Date _____

Signature/date certifying no changes in medical history _____