by Dr. Santos LLC

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CHILD PATIENT INFORMATION

Date ____________________

How were you referred to our practice? ____________________

Child's Name ____________________
First Middle Last

Nickname ____________________

Address ____________________
Street City State Zip

Date of Birth ____________ Age_____ Sex_____ Child's SS#____________

Father's Name ____________________ Mother's Name____________________

Home #____________ Dad's Cell #____________ Mom's Cell #____________

Dad's Work #____________________ Mom's Work # ____________________

E-mail Address____________________

DENTAL INSURANCE INFORMATION

Insurance Company ____________________ Phone #____________________

Policy #____________________ Group #____________________

Insured Name ____________________ SS #____________ D.O.B.___/___/___

Insured Address ______ ____________________

Insured Employer's Name ____________________

Insured Employer's Address ____________________
Street City State Zip

Insured Employer's Phone #____________________

SECONDARY INSURANCE INFORMATION

Insured Name ____________________ SS #____________ D.O.B.___/___/___

Insured Employers name____________________

Insured Employer's Address ____________________
Street City State Zip

Insured Employer's Phone #____________________

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? ____________

IF NOT, HOW LONG SINCE THE LAST EXAM ?____________________

PLEASE STATE REASON FOR CHILD'S VISIT OR MAJOR DENTAL COMPLAINT: ____________
____
____
____

Rev. 2/19

(OVER)

CHILD'S HEALTH HISTORY

PEDIATRICIAN OR FAMILY PHYSICIAN ____

PHONE # ____

Please answer all questions by circling "Yes" or "No" and fill in all blank spaces when indicated. Your answers are for our records only and will be considered confidential.

1. Does your child have any health problems? YES NO
2. If yes, what are the problems? ____
   ____
3. Has your child ever been hospitalized? YES NO
   Date ____________________ Reason ____________________
   ____
4. List **ALL** medication your child is taking:
   Drug Name ____________________ Dosage ____________________ Frequency ____________
   Drug Name ____________________ Dosage ____________________ Frequency ____________
   Drug Name ____________________ Dosage ____________________ Frequency ____________
5. Does you child have any history of the following:
   PLEASE CHECK IF YES (✔):
   Heart Trouble ____________________ Thyroid Problems ____________________
   Asthma ____________________ Rheumatic Fever ____________________
   Diabetes ____________________ Allergies ____________________
   Epilepsy ____________________ Mitro Valve Prolapse ____________________
   Any artificial devices ____
   AIDS, ARC or positive antibody test to HIV or HTLV III ____________________
   Other ____
6. Has your child experienced any unfavorable or unpleasant reaction from any previous dental or medical care? YES NO
7. Does your child receive flouride of any kind at home or school? YES NO
   How often ____
8. Has your child had orthodontic treatment or evaluation? YES NO

To the best of my knowledge, all of the preceeding answers are true and correct. I also certify that the diagnosis, nature of treatment, fees, payment options, risks, benefits, alternatives and conseqences were answered in full and understood. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I give my consent for dental treatment.

Signature of Parent/Guardian ____________________ ***Signature of Dentist*** ____________________