



Dr. Steven Solow & Dr. Scott Solow

990 City Line Avenue • Wynnewood, PA 19096 • Phone: (610) 649-8383

Medical Arts Building • Suite 1014 • 1601 Walnut Street • Philadelphia, PA 19102 • Phone: (215) 665-1518

PATIENT INFORMATION FORM

The information requested below is very important. For parents of children, complete this form for your child. Please make your answers as complete and accurate as possible. This will help us provide the best possible health service for you or 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 _____

Name of school _____

Telephone numbers: Home _____ Business: MOM _____ DAD _____

Home E-mail: _____ Whom may we thank for referring you to us? _____

Father's name _____ SS# _____ DOB _____ Occupation _____

Mother's name _____ SS# _____ DOB _____ Occupation _____

Father's Dental Insurance Co. _____ Employer _____

Mother's Dental Insurance Co. _____ Employer _____

Brother's' and Sisters' Names and Ages _____

Name and address of Physician (Routinely Visited) _____

DENTAL AND MEDICAL HISTORY: (Please circle YES or NO where indicated)

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
6) Does the child have any abnormal behavior?.....	YES	NO
7) Were there any problems during pregnancy, delivery or during the child's first year 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 a history of:		
Excessive or Prolonged Bleeding.....	YES	NO
High Blood Pressure.....	YES	NO
Kidney Disease.....	YES	NO
Diabetes.....	YES	NO
Tuberculosis.....	YES	NO
Behavior Problems.....	YES	NO
Cancer or Tumors.....	YES	NO
Speech Problems.....	YES	NO
Hearing Problems.....	YES	NO
Birth Defects.....	YES	NO
Heart Murmur.....	YES	NO
AIDS or AIDS Virus carrier.....	YES	NO
Cerebral Palsy.....	YES	NO
Sickle Cell Disease or Trait.....	YES	NO
Heart trouble.....	YES	NO
Asthma.....	YES	NO
Liver Disease.....	YES	NO
High Fevers.....	YES	NO
Anemia.....	YES	NO
Hepatitis.....	YES	NO
Nutritional Problem.....	YES	NO
Convulsions (Seizures).....	YES	NO
Any special problem not listed above?.....	YES	NO
X-Ray Treatment.....	YES	NO

10) Please describe any current medical treatment, including drugs, pending surgery, recent injuries or any other information the doctor should be aware of: _____

11) Female patients: Has menstruation begun?..... YES NO

12) Describe the child's learning process for his/her age (circle one): slow average advanced

13) Childs' Interests, hobbies or pets _____

14) 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 Dr. Steven Solow & Dr. Scott Solow 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 Dr. Solow 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.

Signed _____

Date _____