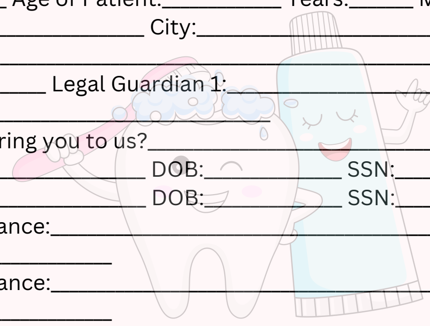
Patient Information Form

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:

990 City Line Avenue
Wynnewood, PA 19096
610-649-8383

1601 Walnut Street, Suite 1014
Philadelphia, PA 19102
215-665-1518

Dr. Steven Solow
Dr. Scott Solow
Dr. Alex Rosner