MEDICAL HISTORY AND PERTINENT INFORMATION - CHILD

PATIENT'S FULL NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
HOME PHONE	WORK PHONE		CELL PHONE
ADDRESS		SCHOOL AND GRADE	
FATHER'S NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
HOME PHONE	WORK PHONE		CELL PHONE
ADDRESS			
EMPLOYER	ADDRESS		
MOTHER'S NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
HOME PHONE	WORK PHONE		CELL PHONE
ADDRESS			
MOTHER'S EMPLOYER	ADDRESS		
STEP-PARENT'S NAME		PREFERRED NAME	
BIRTHDATE		SOCIAL SECURITY #	
HOME PHONE	WORK PHONE		CELL PHONE
ADDRESS			
STEP-PARENT'S EMPLOYER	ADDRESS		
FATHER'S DENTAL INSURANCE		EMPLOYEE I. D. #	
GROUP #	CONTRACT OR POLICY #		INS. CO. PHONE #
FAMILY MEMBERS COVERED BY POLICY			
MOTHER'S DENTAL INSURANCE		EMPLOYEE I. D. #	
GROUP #	CONTRACT OR POLICY #		INS. CO. PHONE #
FAMILY MEMBERS COVERED BY POLICY			
STEP-PARENT'S DENTAL INSURANCE		EMPLOYEE I. D. #	
GROUP #	CONTRACT OR POLICY #		INS. CO. PHONE #
FAMILY MEMBERS COVERED BY POLICY			

MEDICAL AND DENTAL HISTORY

FIRST VISIT TO A DENTIST?	IF NOT, LAST VISIT DATE
ANY PAIN, DISCOMFORT OR KNOWN PROBLEMS?	
DOCTOR'S NAME	PHONE # AND LOCATION
DOES YOUR CHILD REQUIRE ANTIBIOTICS PRIOR TO DENTAL VISITS?	LIST ALLERGIES
LIST MEDICATIONS YOUR CHILD IS PRESENTLY TAKING:	

CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR CHILD

HEART TROUBLE	SINUS PROBLEMS	ASTHMA	CANCER	AIDS
HIGH BLOOD PRESSURE	FAINTING	HIV POSITIVE	CHEMOTHERAPY	HYPOGLYCEMIA
LOW BLOOD PRESSURE	STROKE	EMPHYSYMA	ARTHRITIS/GOUT	DEPRESSION
HEART MURMUR	DIABETES	TUBERCULOSIS	RADIATION TREATMENT	PSYCHIATRIC CARE
CONGENITAL HEART DEFECT	LIVER DISDEASE	HEPATITIS A	THYROID DISEASE	DRUG ADDICTION
ARTIFICIAL HEART VALVE	LUNG DISEASE	HEPATITIS B	SCARLET FEVER	BLEEDING PROBLEMS
BLOOD DISORDER	GLAUCOMA	HEPATITIS C	JAW PAIN	BRUISE EASILY
PACEMAKER	VENEREAL DISEASE	ARTIFICIAL JOINT	FREQUENT HEADACHE	HEMOPHILIA
ANEMIA	COLD SORES	KIDNEY TROUBLE	SEIZURES	NERVOUSNESS
CHEST PAIN	RHEUMATIC FEVER	SINUS TROUBLE	SICKLE CELL ANEMIA	NONE OF THE ABOVE

OTHER MEDICAL CONDITONS:

TODAY'S DATE	PATIENT SIGNATURE	STAFF SIGNATURE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY INSURANCE CLAIMS AND DO HEREBY AUTHORIZE DIRECT PAYMENT OF MY DENTAL BENEFITS TO DR. CABELL.

I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL COSTS OF DENTAL CARE. Signature_____

WHOM MAY WE THANK FOR RECOMMENDING OUR OFFICE?