WHITE OAK FAMILY DENTISTRY



PATIENT HISTORY RECORD

FIRST	NAME	MIDDLE	LAST NAME		NICKNAME
AGE_	DATE (OF BIRTH	MALE	_FEMALE	HOME PHONE
НОМІ	E ADDRESS			CITY	ZIP
E-MA	IL ADDRESS				
Whom	may we thank				
for referring you?CF			ILD'S SCHOOL		GRADE
		E CHILD'S SIBLINGS:			
	AL HISTORY:	E CHIED 5 SIBEINGS.	Y N	Cerebral Pa	lev
		d's first visit to the dentist? If no			
1 11		te of child's last visit			
	approximate dat	of child 5 last visit	— Y N		
Y N	Is your child's w	vater fluoridated?	— Y N		Fever
ΥN		ing any fluoride supplements?	YN		
ΥN		ever had any jaw pain or tendern			lood Disorders
ΥN		brush their teeth daily?	Y N		reathing Problems
ΥN		floss their teeth daily?	YN		
		ny of the following habits?	YN	Tuberculosis (TB)	
Y N		sucking / pacifier	YN		Heart Defect
ΥN	Grinding / Bruxi		Y N		
ΥN	Nail biting		Y N		
ΥN	Mouth breathing	2	ΥN		
ΥN	<u> </u>		ΥN		
ARE THERE ANY OTHER CONCERNS YOU WOULD				Please expla	
LIKE TO BRING TO OUR ATTENTION?				Any hospita	
				Please expla	
			Y N	Kidney / Li	ver problems
MEDICAL HISTORY:			Y N		/ Disabilities / Special Needs
HeightWeight				Please expla	ain:
Child's Physician			Y N		
Family Dentist				Latex Aller	
Phone #Date of last visit				Food Allergies	
	s current physical		Pleas	se list all medica	tions your child is allergic to:
Good ₋	Fair	Poor		7*	
Please	list all medicatio	ons your child is currently taki	ing: Pleas	se discuss any m	edical conditions your child has:

MEDICAL HISTORY CONTINUED:

Has your child ever had any of the following medical problems?

Y N Blood Transfusion

MOTHER'S INFORMATION	FATHER'S INFORMATION
Mother's nameBirth date	rainer's name
Address (if different)	Father's name
Home phone	Home phone
Work phone	Work phone
Cell phone	Cell phone
Occupation	Occupation
Employer	Employer
Employer's address	Employer's address
DENTAL INSURANCE INFORMATION	
Name of 1st Insurance	Group #
Subscriber Name	DOB SS#
Employer Phone #	Address
Relationship to child: mother father step	Group #
Name of 2 nd Insurance	Group # OOBSS# Address o-motherstep-fatherguardianother
Subscriber Name D	OOBSS#
EmployerPhone #	Address
Relationship to child: motherfatherstep	-motherstep-fatherguardianother
Emergency Contact: (list someone who does i	not live in household)
Name	Phone #
NAME OF DEDGON DEGRONGIBLE FOR	ACCOUNT
NAME OF PERSON RESPONSIBLE FOR Address (if different)	ACCOUNT Work Phone
Address (II different)	Notice I notic work I notic
CONSENT FOR DENTAL TREATMEN	NT•
Before any dental procedures are performed including this signed permission statement must be obtained for procedures, although their occurrence is not frequent the administration of topical fluoride rinses, biting to numbness, infection, prolonged bleeding, discolorate surgery for removal. Children with HEART disease bacterial endocarditis (heart infection). You, the partyour child.	ing radiographs, diagnostic aids, local/topical anesthesia, nitrous oxide, oral sedation or general from the parent/guardian. Some risks and complications are known to be associated with dentant. The most common complications associated with pediatric dental treatment include: naused congue/lip following the administration of local anesthesia. Less common complications include tion, vomiting and injury to nerves near treatment site, fracture of tooth root, which may require are required to take antibiotics before and following dental treatment to minimize the risk of the informed of ALL dental services and fees for services BEFORE any are
I hereby certify that the foregoing informati	tion is correct and that I have read and understand this consent form.
Signature of Parent or Guardian	Date
History Update: The parent or guardian time of service unless prior arrangement I have reviewed my child's health history	
DATESIGNATURE	COMMENTS