DENTISTRY SUITE 508 • 12840 RIVERSIDE DRIVE • NORTH HOLLYWOOD, CALIFORNIA 91607

PLEASE PRINT THE FOLLOWING INFORMATION
This information is Important for Our Records and for Your Child's Health

Chart No: ________________ Patient ID: __________
Birth date: ______________________
Gender: Male / Female
Patient: ______________________________________ Age: ______________
(Last) (MI) (First)

Parents (Name in full) Father: ____________________ Mother: ____________________
Residence Address: ____________________ City: ______________ Zip: __________
Residence Phone: ____________________ Business Phone: ____________________
Parent Employed By: ____________________ Occupation: ____________________
Business Address: ____________________ City: ____________________
Name of Physician: ____________________ City: ____________________
*Referred By: ____________________ Former Dentist: ____________________
List children in family who are patients here: ______________________________
*Persons responsible for this account: ______________________________
*Driver's License Number *Father:* ____________________ *Mother:* ____________________
Father's SS#: ______________ Dental Insurance Yes___ No___ Carrier: ______________
Mother's SS#: ______________ Dental Insurance Yes___ No___ Carrier: ______________

PLEASE ANSWER EACH QUESTION

Check One: Yes / No

1. Is your child in good health? _____ _____
2. Was your child ever hospitalized? _____ _____
3. Date of last physical exam ______________________
4. Is your child under medical care? _____ _____
5. Is your child taking medication? _____ _____
   If yes, for what? And what medications?
   ____
6. Has your child ever had a serious illness or operation? _____ _____
7. Does your child have (or ever had) any of the following conditions?
   a. Rheumatic Fever or Rheumatic heart disease _____ _____
   b. Congenital heart disease (i.e. murmur) _____ _____
   c. Cardiovascular disease
   d. Asthma _____ _____
   e. Fainting spells or seizures _____ _____
   f. Hepatitis, jaundice or liver disease _____ _____
   g. Diabetes _____ _____
   h. Arthritis _____ _____
   i. Stomach ulcers _____ _____
   j. Kidney trouble _____ _____
   k. Tuberculosis (TB) _____ _____
   l. Persistent cough, cough up blood _____ _____
   m. Epilepsy _____ _____
   n. Sickle Cell disease _____ _____
   o. Emphysema _____ _____
   p. Psychological treatment _____ _____
   r. Cerebral palsy _____ _____

Check One: Yes / No

   s. Mental retardation _____ _____
   t. Hearing Disability _____ _____
   u. Developmental disability _____ _____
   v. Abnormal bleeding associated with previous surgery, extractions or accidents _____ _____
   w. Required a blood transfusion _____ _____
   x. Blood disorders (i.e. anemia) _____ _____
   y. Surgery, x-ray or chemotherapy for a tumor growth or other condition _____ _____
   z. AIDS _____ _____
8. Is your child allergic to, or reacted adversely to any of the following:
   a. Local anesthesia _____ _____
   b. Penicillin or other antibiotic _____ _____
   c. Sulfa drugs _____ _____
   d. Barbiturates, sedatives, or sleeping pills _____ _____
   e. Aspirin _____ _____
   f. Any other? ______________________
9. Has your child experienced any unfavorable reaction from any previous dental treatment? _____ _____
   If yes, please explain ______________________
10. Date of last dental exam ______________________
11. Has your child ever had any orthodontic? treatment? _____ _____

ADOLESCENT WOMEN

12. Are you pregnant now or think you may be? _____ _____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medications, I will inform the dentist at the next appointment. My signature below is my consent for treatment of the above mentioned child.

______________________ ______________________ ______________
Signature Relationship Date