toothtales™

PATIENT INFORMATION

Please circle best means of contacting you: home phone / cell phone / email

Patient name: _____ Nickname: _____

Birthday: _____ Age: _____ Grade: _____ Sex: male / female

Names & age of brothers/sisters _____

School: _____ Child's learning: slow / average / accelerated

Child's interests: _____ Name of pets: _____

Does your child have any special needs? _____ Any phobias? _____

Whom may we thank for referring you to us? _____

What is the reason for your child's visit? _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y / N

Insurance co.: _____ Group/policy #: _____

Policy owner name: _____

Insurance co. address: _____

Insurance co. phone #: _____ Relationship: _____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Dr. Chen's professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE: _____ Relationship: _____ date: _____

HEALTH HISTORY

Child's pediatrician: _____ Phone number: _____ Last physical: _____

Is your child under a physician's care now? Y / N if yes, reason: _____

Any hospitalizations or surgery? Y / N if yes, when and explain: _____

Is there excessive bleeding when cut? Y / N if yes, please explain: _____

Is your child currently taking any medications? Y / N if yes, please list: _____

Does your child have any allergies? Y / N if yes, please list: _____

Please check if your child has been treated for any of the following:

○ heart disease	○ blood transfusions	○ asthma	○ blood dyscrasias
○ liver/GI disease	○ anemia	○ diabetes	○ AIDS/HIV
○ kidney disease	○ rheumatic fever	○ depression/anxiety	○ mental delays
○ speech / hearing	○ seizures / epilepsy	○ premature birth	○ physical delays
○ cerebral palsy	○ congenital birth defects	○ emotional	○ thyroid disease
○ cancer / tumors	○ recurrent headaches	○ measles / mumps	○ drug / alcohol abuse
○ tuberculosis	○ fainting	○ TMJ problems	○ other
○ down's syndrome	○ eating disorders	○ chemo /radiation therapy	○

Please elaborate on any items checked: _____