Valley Pediatric Dentistry

Patient Information

Patient Name: _____
Last First MI (Preferred Name)

Date of Birth: ___/___/___ **SSN#:** _____ **Gender:** □ Male □ Female

Address: _____
Street Apt #

_____
City State Zip Code

Health Information

Date of Last Dental Exam: _____ **X-rays taken?** Y N **Reason for this Visit:** _____

Have you ever had any of the following? Please circle Yes or No.

ADD/ADHD	Y N	Dizziness	Y N	Herpes	Y N	Respiratory Problems	Y N
AIDS/HIV Positive	Y N	Down Syndrome	Y N	High Blood Pressure	Y N	Rheumatic Fever	Y N
Allergies (Seasonal)	Y N	Drug Addiction	Y N	Hypoglycemia	Y N	Rheumatism	Y N
Anxiety/Panic	Y N	Epilepsy or Seizures	Y N	Jaundice	Y N	Sinus Problems	Y N
Asthma	Y N	Excessive Bleeding	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Autism	Y N	Fainting Spells	Y N	Kidney Problems	Y N	Stomach Problems	Y N
Blood Disease	Y N	Frequent Cough	Y N	Leukemia	Y N	Stroke	Y N
Cancer	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Glaucoma	Y N	Low Blood Pressure	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Head Injuries	Y N	Mental Disorders	Y N	Tumors or Growths	Y N
Congenital Heart Disorder	Y N	Heart Disease	Y N	Nervous Disorders	Y N	Ulcers	Y N
Convulsions	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Venereal Disease	Y N
Developmentally Delayed	Y N	Hepatitis A	Y N	Pregnancy	Y N	Yellow Jaundice	Y N
Diabetes	Y N	Hepatitis B or C	Y N	Radiation Treatment	Y N	Other	Y N

Please list any serious illness not listed above: _____

Do you have any drug allergies? □ Yes □ No | If yes, please explain: _____

List any medication(s) the patient is currently taking: _____

Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain: _____

Have you ever had any of the following habits?

□ Lip Sucking/Biting □ Nail Biting □ Nursing/Bottle Habits □ Thumb/Finger Sucking

Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain: _____

Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain: _____

Name of Physician: _____ **Phone number:** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian **Date**

Responsible Party Information

The following is for: □ the patient's parent(s) or legal guardian □ the person responsible for payment

Name: _____ **Date of Birth:** ___/___/___

Relationship to Patient: □ Mother □ Father □ Other: _____ **SSN#:** _____

Phone (Home): _____ **(Cell):** _____ **Email:** _____

Address: _____

Street **Apt #**

_____

City **State** **Zip Code**

The following is for: □ the patient's parent(s) or legal guardian □ the person responsible for payment

Name: _____ **Date of Birth:** ___/___/___

Relationship to Patient: □ Mother □ Father □ Other: _____ **SSN#:** _____

Phone (Home): _____ **(Cell):** _____ **Email:** _____

Address: _____

Street **Apt #**

_____

City **State** **Zip Code**

Insurance Information

PRIMARY

Policy Holder: _____ **Date of Birth:** ___/___/___

Last **First** **MI**

SSN#: _____ **Patient's relationship to insured:** □ Self □ Child □ Other: _____

Insurance Co.: _____ **ID #:** _____ **Group #:** _____

Insurance Co. Address: _____

Street **City** **State** **Zip Code**

Policy Holder's Employer:

SECONDARY

Policy Holder: _____ **Date of Birth:** ___/___/___

Last **First** **MI**

SSN#: _____ **Patient's relationship to insured:** □ Self □ Child □ Other: _____

Insurance Co.: _____ **ID #:** _____ **Group #:** _____

Insurance Co. Address: _____

Street **City** **State** **Zip Code**

Policy Holder's Employer: _____

Initials (Patient, Parent, or Guardian): _____ **Date:** _____ **Initials (Staff):** _____ **Date:** _____