Date ________________

PATIENT INFORMATION SHEET

Patient Information

Patient's Last, First Name ______________________ Nickname __________ B.D. ________ Age _____

Male or Female   Was patient adopted? Y or N

Patient's Address ________________________________ City _______________ Zip ___________

List Family Siblings: _______________________________________

Parent Last, First name ___________________________ 1st # __________ (**Cell or Land**); 2nd # __________

Address (if different than above)____

Parent Last, First name ___________________________ 1st # __________ (**Cell or Land**); 2nd # __________

Address (if different than above)____

Parent's Information (Whether you have insurance or not)

Parent

B.D. __________ S.S. # ________________ Group # ____________ Sub/ID# __________________

Dental Ins/Address ____Phone ______________

Employer _______________ Occupation __________ Work # ______________ Primary or Secondary

Parent

B.D. __________ S.S. # ________________ Group # ____________ Sub/ID# __________________

Dental Ins/Address ____Phone ______________

Employer _______________ Occupation __________ Work # ______________ Primary or Secondary

Person Financially responsible for account? _______________________ MC/Visa, Care Credit, Online via website, are also accepted.

Would you like to receive statements on your account via email? Yes or No

Confirming Appointments: Our goal is to verbally confirm each appointment, utilizing multiple means.

*** If you need to cancel, please contact our office at least 24 hours prior to your appointment. ***

Email, Text and Voice confirmations. Email _______________________Text __________ Voice ______________

Dental Information

What is the purpose of this dental visit? ____

X-rays from another office? They can be emailed to office@thefunkidsdentist.com. Previous Dentist _______________

How did you hear about our office? ________________________

Patient's Medical Information

Pediatrician/Physician _____________________ Phone ( ) ______________ Any history of the **following:**

Allergies (Incl: medication, environmental & food) ___________________________ Y ___ N___

Condition	Y/N	Condition	Y/N
Epilepsy	Y ___ N___	Autism/Asperger's	Y ___ N ___
HIV Positive	Y ___ N ___	Convulsions	Y ___ N ___
Blood Disorders	Y ___ N ___	Cerebral Palsy	Y ___ N ___
Anemia	Y ___ N ___	Down Syndrome	Y ___ N ___
Excessive Bleeding	Y ___ N ___	Emotional Problem	Y ___ N ___
Leukemia	Y ___ N ___	Learning Disability	Y ___ N ___
Cancer	Y ___ N ___	Attention Def. Dis and/or ADHD	Y ___ N ___
Hepatitis	Y ___ N ___	Speech Impediment	Y ___ N ___
Liver Disease	Y ___ N ___	Hearing Problem	Y ___ N ___
High Blood Pressure	Y ___ N ___	Diabetes	Y ___ N ___
Rheumatic Fever	Y ___ N ___	Skin Problem	Y ___ N ___
Heart Problem	Y ___ N ___	Tuberculosis	Y ___ N ___
Asthma	Y ___ N ___	Tumors	Y ___ N ___
Kidney Disease	Y ___ N ___	Diagnostic Testing	Y ___ N ___
Medications, ____________	Y ___ N ___	Shunts, type? ___________	Y ___ N ___

Other: ______________________

Permission to use your child's full name & photo taken in our office, on our website or for use in our office? Yes / No

Parent Signature ___________________________   Date __________________

Patient Information Updates

Patient's Name ______________________
Has your dental insurance changed? Y or N   If yes, please write the current information and give your card to the Front Desk so that we may make a copy.
____

Has your child's medical history changed? Y or N   If yes, please explain.
____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________   Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N   If yes, please write the current information and give your card to the Front Desk so that we may make a copy.
____

Has your child's medical history changed? Y or N   If yes, please explain.
____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________   Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N   If yes, please write the current information and give your card to the Front Desk so that we may make a copy.
____

Has your child's medical history changed? Y or N   If yes, please explain.
____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________   Date _______________

____
Patient's Name ______________________
Has your dental insurance changed? Y or N   If yes, please write the current information and give your card to the Front Desk so that we may make a copy.
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Has your child's medical history changed? Y or N   If yes, please explain.
____
Is your child on any medications? If yes, name and dosage? _______________________________
Comments: ____
____
Signature: _________________________________   Date _______________