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

Address (if different than above) _____

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

Address (if different than above) _____

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

Parent (#1)

B.D. _____ S.S. # _____ Group # _____ Sub/ID# _____

Dental Ins/Address _____ Phone _____

Employer _____ Occupation _____ Work # _____ Primary or Secondary

Parent (#2)

B.D. _____ S.S. # _____ Group # _____ Sub/ID# _____

Dental Ins/Address _____ Phone _____

Employer _____ Occupation _____ Work # _____ Primary or Secondary

Person Financially responsible for account? _____

*** Mastercard/Visa, CareCredit, Cash, Check and Insurance are accepted for payment on your account ***

Confirming Appointments: If you need to cancel, please contact our office at least 24 hours prior to your appointment. We also offer Text and Email confirmations. Text ____Email ____ (Email Address: _____)

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

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: (Please check if applies)**

o ADD/ADHD	o Developmentally Delayed,	o Heart Defect/Disease
o Anemia	Age Level____	o HIV+/AIDS
o Anxiety/Depression	o Diabetes	o Hydrocephaly/shunt
o Asthma	o Diagnostic	o Learning Disability
o Autism/Asperger's/PDD	o Down Syndrome	o Liver or Kidney Problems
o Birth Defect-Premature/Syndrome	o Eating Disorder	o Orthopedic Pins/Rods/Plates
o Bleeding Disorder	o Epilepsy/Seizures	o Sickle Cell Disease/Trait
o Cancer	o Gastroesophageal/Acid reflux	o Skin Problems
o Cerebral Palsy	o G-Tube Feeding	o Sleep Apnea/Snoring/Gagging
o Chronic Ear Infections	o GI Problem	o Speech Delay/Impairment
o Cleft Lip/Palate	o Hearing Loss/Deafness	o Vision Loss/Impairment
o Cystic Fibrosis		o NONE

Allergies (including drug, environmental, food): _____

Medications: _____

Hospitalizations/Surgeries: _____

Please provide details of anything noted above, and any other significant medical history:

_____

Parent Signature X_____ Date _____

STOP

Patient Information Updates

Patient's Name ________________________________

Has your child's medical history changed? **Yes** **or** **No**

Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

____

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.

____

Signature: X______________________________ Date ______________

Patient's Name ________________________________

Has your child's medical history changed? **Yes** **or** **No**

Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

____

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.

____

Signature: X______________________________ Date ______________

Patient's Name ________________________________

Has your child's medical history changed? **Yes** **or** **No**

Has there been a change in current medications or allergies? **Yes** **or** **No**

If **YES** to any of the above, please explain.

____

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.

____

Signature: X______________________________ Date ______________