PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____ Age: _____ Gender: _____

Phone:_____Home Address:_____

City: _____ State: _____ Zip:_____

MEDICAL HEALTH HISTORY

Does your child have or had any of the following?

❏ Alcohol or drug abuse ❏ Allergies ❏ Anemia ❏ Anesthetic Allergy ❏ Artificial Joints ❏ Asthma ❏ Behavioral Disorders ❏ Blood Problem ❏ Cancer ❏ Drug/Antibiotic Allergy ❏ Dizziness	❏ Epilepsy ❏ Fainting ❏ Heart Disease ❏ Hepatitis A B or C ❏ Latex Allergy ❏ Non-prescription Drugs ❏ Penicillin or other antibiotic allergy ❏ ADHD ❏ Speech Delay ❏ Autism Spectrum Disorder ❏ Latex allergy, or history of allergy in family

Food allergies _____

Medication allergy/allergies _____

List any medications your child is currently taking _____

Does your child have any disease, condition, or problem not listed above that we should know about? (If yes, please explain)

_____

_____

Date of last hospital visit _____

Name of pediatrician _____ Phone number _____

Has your child had any surgeries? _____ If so, date(s) _____

Does your child see any specialists? _____ If so, which ones? _____

The information I have provided is true to the best of my knowledge. I give my consents for my child to be treated today:

Parent/ Guardian Signature_____ Date_____

For the Doctor to complete:

Diagnostics	Exam Findings	Treatment Plan	Completed Treatment
Date:			
Pano			
#Pas/BWX			
IOE			
EOE			

Anesthetics Used:

_____

Progress Notes:

_____

_____

RX Given:

_____

Provider's Signature: _____ Date _____