Budding Smiles of Beaver

PATIENT INFORMATION AND HEALTH HISTORY FORM

Patient's Name ______________________________ Today's date ______________

Patient Information:

Patient's SSN ____________________ Date of Birth ______________ Age ____ Race ____ Sex ____

Biological father ______________________________ Biological mother ______________________________

Court appointed legal guardian (if applicable) ______________________________

Contact information:

Cell phone number ______________ Work number ______________ Home number ______________

E-mail ______________________________ Home Address ______________________________

City ____________________ State ____________________ Zip ______________

For emergencies, provide the contact information of someone other than a person who lives with you:

Name ______________________________ Phone number ______________________________

Best method of contact (select one or more): Text ☐ E mail ☐ Phone call ☐

(3A) Medical history: (Please select Yes or No)

Name of Child's Physician ______________________________ Date last seen ______________

Is your child being treated by a physician at this time? [Yes] [No]

If yes, why? ______________________________

Has your child ever been admitted to a hospital? [Yes] [No]

If yes, why? ______________________________

Has your child ever received general anaesthetic or sedation? [Yes] [No]

If yes, why? ______________________________

Is your child allergic to anything? (food or medicine) [Yes] [No]

If yes, what? ______________________________

Is your child taking ANY medications currently? [Yes] [No]

If yes, what? ______________________________

(3B) Organs & systems: Does your child currently have or has had treatment for any of the following?

[Yes]	[No]	Blood/Circulatory	[Yes]	[No]	Gastrointestinal/Stomach	[Yes]	[No]	Muscles
[Yes]	[No]	Bones	[Yes]	[No]	Heart/ Heart Murmur	[Yes]	[No]	Respiratory/Lungs
[Yes]	[No]	Endocrine Glands	[Yes]	[No]	Kidney	[Yes]	[No]	Skin
[Yes]	[No]	Eyes/Ears/Nose/Throat	[Yes]	[No]	Liver	[Yes]	[No]	Tonsils/Adenoids

(3C) Illnesses:

Has your child ever been diagnosed as having any of the following conditions? ***(tick yes or no for each)***

[Yes]	[No]	Anemia	[Yes]	[No]	Eye Problems	[Yes]	[No]	Rheumatic Fever
[Yes]	[No]	Seasonal allergy	[Yes]	[No]	Excessive Bleeding	[Yes]	[No]	Sickle Cell Anemia
[Yes]	[No]	Arthritis	[Yes]	[No]	Fainting	[Yes]	[No]	Sinus Problems
[Yes]	[No]	Asthma	[Yes]	[No]	Hearing Loss	[Yes]	[No]	Snoring at night
[Yes]	[No]	Brain Injury	[Yes]	[No]	Hemophilia	[Yes]	[No]	Sore Throat - frequent
[Yes]	[No]	Canker sores in mouth	[Yes]	[No]	Hepatitis (Type ___)	[Yes]	[No]	Syndrome___________
[Yes]	[No]	Cancer ___________	[Yes]	[No]	Jaundice	[Yes]	[No]	Tetanus
[Yes]	[No]	Cerebral Palsy	[Yes]	[No]	Herpes	[Yes]	[No]	Tuberculosis
[Yes]	[No]	Chicken Pox	[Yes]	[No]	Measles/ Mumps	[Yes]	[No]	Venereal Disease
[Yes]	[No]	Cleft Lip/Palate	[Yes]	[No]	Mouth Breathing	[Yes]	[No]	Latex Allergy
[Yes]	[No]	Convulsions/Seizures	[Yes]	[No]	Nutritional Deficiency	[Yes]	[No]	Autism
[Yes]	[No]	Diabetes (Type ___)	[Yes]	[No]	Orthopedic Problems	[Yes]	[No]	ADD/ADHD
[Yes]	[No]	Drug/Alcohol Abuse	[Yes]	[No]	Pneumonia/ Bronchitis	[Yes]	[No]	Intellectual disability
[Yes]	[No]	Epilepsy	[Yes]	[No]	Pregnancy	[Yes]	[No]	Psychiatric Disorder
[Yes]	[No]	HIV	[Yes]	[No]	Premature birth	[Yes]	[No]	Sensory issues

Dental history:

What is the primary reason for your visit today? ____

____

Has your child ever been seen by a dentist before? [Yes] [No]

Were X-rays (radiographs) taken in the last visit? [Yes] [No]

Dentist's Name ______________________________________ Date last seen ________________

Is there anything else that you think we should know about your child? ______________________

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I certify that I am the patient's biological parent or court appointed guardian and have provided correct and updated information related to the patient to the best of my knowledge. I understand that the information provided, or lack thereof can impact the treatment provided to the patient. I alone uphold the responsibility of informing the office if there is any change in patient's medical or dental history at each subsequent visit. I will not hold Dr. Ntasha Sethi and her associates or any member of the staff at Budding Smiles of Beaver responsible for any errors or omissions I may have made on this form.

_______________________________ _______________ _______________

Name and signature of Parent/ Legal Guardian   Relationship to Patient   Provider Signature