

THESE QUESTIONS ARE OF GREAT VALUE IN UNDERSTANDING, DIAGNOSING, AND TREATING YOUR CHILD.

Date: _____

Child's Name _____ Name Child Prefers _____
First Middle Last

Date of Birth: Month _____ Day _____ Year _____ Age _____ Male () Female () Weight _____

Child's Residence _____
Street Address City State Zip Phone Number

Billing Residence _____
Street Address City State Zip Phone Number

Name	Place of Employment	Business Phone	Cell Phone
Father _____ <small>First Last</small>	_____	_____	_____

Fathers Date of Birth _____

Mother _____ <small>First Last</small>	_____	_____	_____
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Mothers Date of Birth _____

State Assistance/Title 19 ID# _____

Primary Insured Name _____ D.O.B. _____ SS# _____

Primary Insurance _____ Secondary Insurance _____

Father's Social Security # _____ Mother's Social Security # _____

**If unable to reach parents, person to contact in case of an emergency:

Name _____ Relationship _____ Phone # _____ Cell # _____

By whom were you referred to our office? _____

MEDICAL HISTORY

	YES	NO
Child's Physician or Pediatrician _____		
Are your child's immunizations up-to-date? _____	()	()
Has your child had regular medical check-ups? Date of last visit: _____	()	()
Has your child ever been hospitalized? If yes, reason(s): _____	()	()
Has your child ever been allergic or had an unfavorable reaction to anything? _____	()	()
**If yes, to what? _____		
Is your child taking any medicine now? What kind? _____	()	()
Has your child ever been put to sleep for medical or dental treatment in or out patient? _____	()	()
Does your child have, or ever had, any emotional, mental, or nervous disorder? _____	()	()

Please circle any of the following problems that your child has had:

Heart	Epilepsy	Heart Murmur	Rheumatic Fever	Autism
Kidney	Diabetes	Speech	Tuberculosis	Surgery
Liver	Asthma	Seizures	Cerebral Palsy	Other
Hay Fever	Cleft Palate	Bladder	Excessive Bleeding When Cut	

(Over)