Sammamish Family Dental
Robert L. Humble, DDS

Child's Information

Child's name: ______________________________ Nickname: ______________________________
Birthdate: ___________ Hobbies, Pets: ____
Whom may we thank for recommending us?____

Parents' Information

Mother: ______________________________ S.S. #: ______________Birthdate:________________
Home ph. #: __________________ Work #: _____________________ Cell #: _________________
E-mail: ____
Address: ____
Father: ______________________________ S.S. #: ______________Birthdate:________________
Home ph. #: __________________ Work #: _____________________ Cell #: _________________
E-mail: ____
Address: ____

Account Information

Person responsible for account:________________________________ Relation: _____________
Home ph. #: __________________ Work #: _____________________ Cell #: _________________
Address: □-same as patient ____

Primary dental insurance company: ____
Employer:____Group #: _______________________
Subscriber: _____________________I.D. or S.S. #: ____________________ Birthdate: _________

Secondary dental insurance company: ____
Employer: ___________________________________Group #: ______________________________
Subscriber: _____________________I.D. or S.S. #: ____________________ Birthdate: _________

Updates (please review front and back of form)

Have there been any changes in contact info, insurance or health? Date:______ □-No □-Yes:
____

Have there been any changes in contact info, insurance or health? Date:______ □-No □-Yes:
____

Have there been any changes in contact info, insurance or health? Date:______ □-No □-Yes:
____

Medical History

Name of physician: ______________________________Phone number: _________________

Is your child taking any over-the-counter medications or prescription drugs? □-No □-Yes:

Please list each with dosage: ____

____

Is your child allergic to any of the following?

Y N Local anesthetic (Novocain)
Y N Penicillin or other antibiotics
Y N Codeine
Y N Aspirin
Y N Metal
Y N Latex

Does your child have or ever had any of the following medical conditions or procedures?

Y N Prosthetic heart valves
Y N Heart attack, angina, stroke
Y N Fainting spells, seizures, epilepsy
Y N Mental or psychiatric disorders
Y N Prosthetic joints
Y N High Blood Pressure
Y N Asthma
Y N Cancer
Y N Diabetes
Y N Low Blood Pressure
Y N HIV-positive or AIDS
Y N Blood disorder

Is there any other medical information you'd like us to know? ________________________________

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Dental History

Is this your child's first visit to the dentist? **Y N**

Previous dentist, city:___________________________________ Last exam:_______________

Is your child apprehensive about dental visits? **Y N**

Does he or she usually use laughing gas? **Y N**

Does your child suck his or her thumb or a pacifier? **Y N**

Does your child live in an area with fluoride in the water? **Y N Unsure**

Is he or she taking fluoride supplements? **Y N**

Does your child get cold sores (fever blisters)? **Y N**

How often are your child's teeth brushed?____

Who brushes his or her teeth?

____

How would you describe his or her dental health? □-Excellent □-Good □-Fair □-Poor

Any specific interests, concerns, or additional comments?_______________________________

____

To the best of my knowledge the above personal, medical, and dental information is correct:

Signature of patient/guardian:___________________________________Date: ____