WELCOME

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS# / SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____

Phone _____ SS#/ SIN _____

DL# _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Day _____

_____

Mother

☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father

☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____ State/ Zip/

City _____ Prov. _____ P.C. _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____ State/ Zip/

City _____ Prov. _____ P.C. _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX

☐ I wish to discuss the office's payment policy.

Time 11:01 AM

Medin Family Dental

Date 6/6/2017

Eaglesoft Medical History- child

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following

Are you under a physician's care now? ○ Yes ○ No If yes

Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes

Child's physician? ○ Yes ○ No

Phone?

Date of Last dental visit? ○ Yes ○ No

Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you have, or have you had, any of the following?

Diabetes	○ Yes ○ No	Acid Reflux	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Anemia	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Spina Bifida	○ Yes ○ No	Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Bruise Easily	○ Yes ○ No
Cancer	○ Yes ○ No	Hay Fever	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Cold Sores/Fever Blister	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No		

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____