

**(Children and Students Information Form)
PATIENT REGISTRATION AND MEDICAL HISTORY**

Date _____ (PLEASE PRINT) Home Phone _____
Cell Phone _____
E-mail _____

Patient _____ Legal First Name _____
Last Name Preferred First Name M.I.

Street Address _____ Apt# _____ City _____ State _____ Zip _____

Sex M F Age _____ Birth Date _____

School Status (If college student) Full-time Part-time School Name _____

Father's Name _____

Mother's Name _____

Who is responsible for this account? _____ Relationship to Patient _____

Responsible Parent Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Name of Dental Insurance Company _____ Group Number _____

Insured Person Name _____ Insured Person's Birth Date _____

Insured Person's Social Security # _____ Patient's Social Security # _____

In case of emergency, who should be notified? _____ Phone Number _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following (check boxes that apply):

- | | | |
|-----------------------------------------------------------|---------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Artificial Heart Valves/Joints | <input type="checkbox"/> Coumadin/Blood Thinner | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies to Medication/Drugs | <input type="checkbox"/> Diabetic | <input type="checkbox"/> HIV Positive/AIDS |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Epilepsy/ Seizers | <input type="checkbox"/> Nervous/Panic Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Conditions/Surgery | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy/Radiation Treatment | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Ulcer |

1. Are you currently in good health? YES NO
If "NO", explain _____

2. Are you currently taking any medication at this time? YES NO
If "YES", name of the medications _____

3. Do you have any drug allergies or have you ever had an adverse reaction to any medication? YES NO
If "YES", name of the drug/medication _____

4. Are you currently under care of a physician? YES NO
If "YES", for what condition? _____

5. (Women Only) Do you suspect that you are pregnant? YES NO

6. If patient is a child, what is his/her weight? _____

7. Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment and the billing and processing of insurance claims. I authorize Dr. Baba to perform necessary dental procedures and will not hold him or any member of his staff, responsible for any errors or omissions I may have made in the completion of this form.

Date _____ Parent's Signature(if child is under 18) _____