PATIENT#: ______

AURELIO A. BULA, D.M.D., M.S.

NEW PATIENT MEDICAL AND DENTAL HISTORY

DATE OF BIRTH_____/______/_______ TODAY'S DATE______________________

PATIENT NAME: ____ NICKNAME: __________________ SEX: M F ________
LAST FIRST MIDDLE (Circle) AGE

HOME ADDRESS:____

APT#:_____________CITY:______________________________STATE:________ZIP CODE:____________________

GRADE: __________ SCHOOL:____ CITY:_______________________

PARENT INFORMATION:

MOTHER'S NAME:____________________________________SOCIAL SECURITY#_____________________ HOME PHONE: __________________

EMAIL ADDRESS:______________________________________ MOBILE: _______________________

EMPLOYER:_________________________________OCCUPATION:_______________________ WORK PHONE: __________________

FATHER'S NAME:____________________________________SOCIAL SECURITY#:______________________ HOME PHONE: _________________

EMAIL ADDRESS:______________________________________ MOBILE: _______________________

EMPLOYER:_________________________________OCCUPATION:_______________________ WORK PHONE: __________________

Name(s) and ages of other children in family: ____

Name(s) of your other children seen in this office: ____

Please list the child's hobbies / interests: ____

How did you hear about us?____

Who may we thank for referring you? ____

Who is accompanying the child today? ______________________________________ Relation: ___________________________

Who has legal custody of this child? ____

FORM OF PAYMENT___CASH ___VISA/MC ___DISCOVER ___AMERICAN EXPRESS ____CARE CREDIT

<u>DENTAL INSURANCE INFORMATION:</u>

Name of Primary/Subscriber: ____ Date of Birth____/_____/_____

Primary's Social Security #: ____________________________ Relationship to Patient: ______________________________

Name of Insurance Carrier: ____________________________ Insurance Phone Number: ____________________________

Member ID: ________________ Group #: ___________________ Do you have other Dental Insurance: ____Y ____N

<u>MEDICAL INSURANCE INFORMATION:</u>

Name of Primary/Subscriber: ____ Date of Birth____/_____/_____

Primary's Social Security #: ____________________________ Relationship to Patient: ______________________________

Name of Insurance Carrier: ____________________________ Insurance Phone Number: ____________________________

Member ID: ________________ Group #: ___________________ Do you have other Medical Insurance: ____Y ____N

EMERGENCY CONTACT:

His / Her Name: ____ Relation: _________________________________

Work Phone #: (______)_____________________________ Home Phone #: (_____)_______________________________

Cell / Other Phone #:(______)____

MEDICAL HISTORY

Child's Physician: ____Phone #: ________________________

Date of last visit: ____________________ Address: ____

Street City State Zip

Is the child currently under the care of a physician? ____Yes ____No If yes, please explain:

____

Please describe the child's current physical health: ____Good ____Fair ____Poor

Are Immunizations Current? ____Yes ____No

Please list all medications that the child is currently taking: ____

Please list all medications / foods / other that cause the child allergic reactions: __________________________________

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ___Y___N

When? _____________ Reason: ____

Has your child ever had a reaction to or a problem with anesthetic? Please explain______________________________________

____

Has your child had a reaction/allergy to an antibiotic, sedative or other medication?______________________________________

Is your child allergic to latex, metals, acrylics, or dyes? ____Y ____N List____

Did your child have any complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions?

____

Has the PATIENT been diagnosed with or treated for any of the following *(Please circle Y or N)?*

Y N Hearing Difficulties
Y N Speech Difficulties
Y N Emotional Difficulties
Y N Learning Problems/Delays
Y N Handicaps/Disabilities
Y N ADD/ADHD
Y N Autism
Y N Eye Problems
Y N Cleft Palate/Lip
Y N Liver Problems or Hepatitis
Y N Rheumatic Fever
Y N Diabetes
Y N Blood Transfusion
Y N Bleeding Problems_______________
Y N Anemia or Poor Blood
Y N Ashtma
Y N Kidney Problems
Y N Skin Problems

Y N Heart Problems
Y N Muscle, Joint, Bone Problems
Y N Epilepsy or Seizures
Y N Cerebral Palsy
Y N Sickle Cell Anemia
Y N Disease(s) Affecting Normal Growth
Y N Birth Defects
Y N AIDS/HIV+
Y N Organ Transplant
Y N Tuberculosis
Y N Hormonal Problems
Y N Cancer
Y N Dietary Restrictions
Y N Snoring/Mouth Breathing or Excessive Gagging
Y N Other_____________________

If there is history of the following in the PATIENTS FAMILY *(Please circle Y or N)*

Y N High Blood Pressure
Y N Allergies
Y N Seizures or Convulsions
Y N Diabetes
Y N Tuberculosis
Y N Obesity
Y N Mental Retardation
Y N Bleeding Problems ___________
Y N Heart Disease
Y N Kidney Problems
Y N Liver Problems
Y N Asthma
Y N Birth Defects
Y N Muscle Weakness
Y N AIDS/HIV+
Y N Other_____________________

Please discuss and provide details of the above and any other medical problems the child has / had:

____

____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told?

____

____

Is there anything you would like to discuss with the doctor in private or without your child being present? _____________

DENTAL HISTORY

What is the primary reason for today's visit? ____

Is your child currently having problems with any of the following?

___Cavities ___Toothache ___Sensitive Teeth ___Trauma ___Gum Infection ___Color of Teeth ___Tooth Alignment

___Other _______________

Has the child experienced problems with previous dental work? ___Yes ___No Explain: ______________________

Is the child's home water supply fluoridated? Yes No

Does the child brush his / her teeth daily with fluoride toothpaste? ___Yes ___No

Do you give the child any other form of fluoride? ___Yes ___No If yes, what? __________________

Does the child floss his / her teeth daily? ___Yes ___No

Was your child bottle / breast-fed? ___Yes ___No If yes, what age was it completely stopped? ______________

Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _______________________________________

Previous/Present (circle) Dentist: _____________________________________

Date of last Visit: _______________________ Why did you leave your last Dentist? ____________________________

What did you like most about any dentist you have seen?_____________________________________ Least?____________

____

Please describe any medical treatments including drugs, pending surgeries, recent injuries, or any information that you would like to make us aware of that has not been covered by the medical or dental history?

____

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I certify that I have read, understand, and agree to the above information and agreement. I further certify that the above questions have been accurately answered. I understand that providing inaccurate information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third-party payors and/or health practitioners. I hereby consent to have photographs, x-rays and any other means of recording taken in order to improve my child's dental treatment that my dentist deems necessary.

Signature ____ Date ____________________

Relationship to Child ______________________________