The Cowboy Dentists

Pediatric Dentistry

PATIENT HISTORY FORM

STEPHEN D. MILLER, D.D.S., L.T.D.
AARON D. MILLER, D.M.D.

WE CARE FOR CHILDREN
WE TREAT TEETH

Patient's Name: _____ Sex _____ Referred By _____
Last First Middle Nickname

Were you referred by a family who comes here because of Miss Erika's school programs. Yes or No (circle)

Date of Birth: _____ Family Dentist _____ Child's Physician _____

Patient's Address _____ Phone _____

Siblings in our Practice _____ Person Responsible for Account _____

Father/Guardian Name _____ Mother/Guardian Name _____
Last First Middle Last First Middle

Address _____ Address _____
Street Street

_____ _____
City/State Zip Phone City/State Zip Phone

_____ _____
Employer Occupation Work Phone Employer Occupation Work Phone

S.S. No. _____ Father/Guardian S.S. No. _____ Mother/ Guardian

Birthdate _____ Cell Phone # _____ Birthdate _____ Cell Phone # _____

Is PATIENT covered by Dental Insurance? YES NO If yes, please list: (Primary Ins first)

1. _____
INS COMPANY NAME POLICY/GROUP# ID# SUBSCRIBER'S NAME

2. _____
INS COMPANY NAME POLICY/GROUP# ID# SUBSCRIBER'S NAME

MEDICAL and DENTAL HISTORY - Has your child had any history of the following (If yes, please check)

____ Heart Murmur	____ Heart Trouble	____ Drug Allergy	____ Allergy (other)	____ Prematurity
____ Diabetes	____ Kidney	____ Seizures	____ Bleeding Disorder	____ Depression
____ Asthma	____ Liver/Hepatitis	____ Hearing	____ Rheumatic Fever	____ Defiance Disorder
____ Thyroid	____ Hyperactivity	____ Tuberculosis	____ Malignancies	____ Special Needs

Allergy to Penicillin, Amoxicillin and/or Local Anesthesia (Novocain), nut allergies, and severity of reaction _____

Other: _____

Does your child currently take medication? If yes, please list _____

What is your main reason for bringing your child to this office? _____

Is this your child's first dental visit? (Please Circle) YES NO If NO, when was last visit? _____

Is your child taking Fluoride vitamin? _____ Do you have well or spring water? _____

Who was your child's previous dentist and how was care accepted by your child? _____

_____

How would you describe your child's temperament? _____

Child's Interests, Hobbies, Talents, etc. _____

Please list any questions you would like to have answered. _____

_____

This information is correct to the best of my knowledge. I authorize the dental team to perform the necessary dental services my child may need. I also authorize my physician and past dentist to release records to Dr. Stephen Miller.

SIGNATURE OF PARENT/GUARDIAN and DATE _____