Croasdaile
DENTAL ARTS
Your Smile. Our Passion.

CHILD MEDICAL HISTORY FORM pg1

SELECT YOUR DENTIST: **DATE: ________________**

____ Dr. Will Turner **____ Dr. Jason Butler** **____ Dr. Virginia Mayo**

PATIENT INFORMATION: ___Married ___Single
Name ____ ___Male ___Female
(LAST) (FIRST) (MIDDLE INITIAL) DOB _________________
Address: ____, State ______ Zip ______________
What name would you like to be called in this office? ____
Whom may we thank for referring you?____
School/College: ________________ City ______________ State _______ _ __Full Time ___Part Time

FAMILY INFORMATION:

MOTHER

Name: __________________________________
Address:_________________________________
City _______________ State _______ Zip _____
Home# _______________Work_________Ext___
Cell # _______________ Pager _______________
Email: ___________________________________
Birthdate: ___________ SSN#:_______________
Employer/Occupation: ______________________

FATHER

Name: __________________________________
Address:_________________________________
City_______________ State _____ Zip ________
Home# _______________Work_________Ext___
Cell # _______________ Pager ________________
Email: ____________________________________
Birthdate: ___________ SSN#:__________________
Employer/Occupation: _________________________

Please name two people to contact outside of immediate family in case of emergency: (not living with you)
Name: _______________________________ Home# ________________ Work#______________
Address: _____________________________ City: _____________ State: ______ Zip: _________

Name: _______________________________ Home# ________________ Work#______________
Address: _____________________________ City: _____________ State: ______ Zip: _________

FINANCIAL INFORMATION: (note: please review our Financial Policy form)
Please check the person financially responsible for the account
____ Patient ____ Father ___ Mother ____Guardian ____Spouse ___Other (specify) _______________

Does responsible party have an account with this office ____Yes ____ No
Method of Payment: ____ Check _____ Cash ____ Mastercard/Visa
Where appropriate and necessary, credit bureau reports will be obtained.

Dental Insurance 1

Employee Name: ____________________________
Employer Name: ____________________________
Insurance Co. Name: _________________________
Insurance Co. Address:_________________________
____
Subscriber I.D. #: ___________________________
Group #: ___________________________________
Employee Date of Birth: _______________________

Dental Insurance 2

Employee Name: __________________________________
Employer Name: __________________________________
Insurance Co. Name: ______________________________
Insurance Co. Address:_____________________________
____
Subscriber I.D. #: ________________________________
Group #: ____
Employee Date of Birth: ___________________________

Authorization: I hereby authorize payment directly to Drs. Turner & Butler, DMD, PA and the associate dentist, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.
Responsible Party Signature: ______________________________ **Date: ________________**
State Driver's License #: ____________________________

Please complete the following page regarding Medical History

CHILD MEDICAL HISTORY FORM pg2

Patient Name: ________________________________ Birth Date: ________________________________

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 questions.

Are you under a physician's care now? ___ Yes ___ No If yes, please explain ______________________
Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain ______________________
Have you ever had a serious head or neck injury? ___ Yes ___ No If yes, please explain _____________________
Are you taking any medications? (Rx, OTC, Supplements) ___ Yes ___ No If yes, please list all here ____________________
____
____
____

Do you take, or have you taken, Phen-Fen or Redux? ____Yes ___ No If yes, please explain ______________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ____Yes ___ No If yes, please explain ______________________
Are you on a special diet? ____Yes ___ No If yes, please explain ______________________
Do you use tobacco? ____Yes ___ No
Do you use controlled substances? ____Yes ___ No
Do you have sleep apnea? ____Yes ___No
Do you use a C-PAP machine? ____Yes ___No
Do you use Electronic cigarette? ____Yes ___No

Women are you
____ Pregnant or Trying to get pregnant?
____Nursing?
____Taking oral contraceptives

Are you allergic to any of the following?
____ Aspirin ____Penicillin ____Codeine ____ Acrylic ____Metal____ Latex ____Sulfa Drugs ____ Local Anesthetics
____ Other If yes, please explain: ____

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

____ AIDS/HIV Positive	____ Chest Pains	___Genital Herpes	___ Kidney Problems	___ Rheumatism
____ Alzheimer's Disease	____ Cold Sores/Fever Blisters	___Glaucoma	___ Leukemia	___ Scarlet Fever
____ Anaphylaxis	____ Congenital Heart Disorder	___Hay Fever	___ Liver Disease	___ Shingles
____ Anemia	____ Convulsions	___Heart Attack/Failure	___ Low Blood Pressure	___ Sickle Cell Disease
____ Angina	____ Cortisone Medication	___Heart Murmur	___ Lung Disease	___ Sinus Trouble
____ Arthritis/Gout	____ Diabetes	___Heart Pace Maker	___ Mitral Valve Prolapse	___ Spina Bifida
____Artificial Heart Valve	_____ Drug/Alcohol Addiction	___Heart Trouble/Disease	___ Organ Transplant	___ Stomach/Intestinal
____ Artificial Joint	_____ Easily Winded	___ Hemophilia	___ Osteoporosis	___ Stroke
____ Asthmas	_____ Emphysema	___ Hepatitis A	___ Pain in Joints	___ Swelling of Limbs
____ Blood Clot/DVT	_____ Epilepsy or Seizures	___ Hepatitis B or C	___ Parathyroid Disease	___ Thyroid Disease
____ Blood Disease	_____ Excessive Bleeding	___ Herpes	___ Psychiatric Care	___ Tonsillitis
____ Blood Transfusion	_____ Excessive Thirst	___ High Blood Pressure	___ Radiation Treatment	___ Tuberculosis
____ Breathing Problems	_____ Fainting Spells/Dizziness	___ High Cholesterol	___ Recent Weight Loss	___ Tumors or Growths
____ Bruise Easily	_____ Frequent Cough	___ Hives or Rash	___ Renal Dialysis	___ Ulcers
____ Cancer	_____ Frequent Diarrhea	___ Hypoglycemia	___ Rheumatic Fever	___ Venereal Disease
____ Chemotherapy	_____ Frequent Headaches	___ Irregular Heartbeat		

Have you ever had any serious illness not listed above? ____ Yes ____ No If yes, please explain: ____
____

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.

I understand that Croasdaile Dental Arts (Drs. Turner & Butler, DMD, PA) and their associate dentist requires that a new Medical History Form be completed once a year.

Signature of Patient, Parent or Guardian ______________________________ Date: ______________________________