



PERSONAL HEALTH HISTORY OF:

Child's Name _____ Nickname _____

Sex _____ Date of Birth _____ Place _____

Home Address _____
Street City State Zip

Father's Name _____ MR. _____ DR. _____ Other _____

Father employed by _____ Social Security No. _____

Phone: (h) _____ (c) _____ (w) _____ Email: _____

Mother's Name _____ MS. _____ MRS. _____ DR. _____ Other _____

Mother Employed by _____ Social Security No. _____

Phone (h) _____ (c) _____ (w) _____ Email: _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Name and birthdates of Other Children: _____

Name and Address of Child's Physician/Pediatrician _____
Name Phone

Address

Name and Address of Previous Dentist and Date of Visit _____
Name Phone

Address Date of Last Visit

Referred by: _____

Is your child covered by dental insurance? Yes No

Primary Insurance _____ Group # _____ Mom Dad

ID # _____ Subscriber's Date of Birth _____

Secondary Insurance _____ Group # _____ Mom Dad

ID # _____ Subscriber's Date of Birth _____

