Philip E. Strevey, DDS, FAGD
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Confidential Information - Please complete, sign, date, fax, or mail to us prior to appointment.

Child Patient Information under the age of 14

Name _____ _____ Male ☐ Female ☐
First Middle Last Child's Preferred Name
Date of Birth_____ Age _____ Grade _____ School _____
Parent or Guardian *(Please print)* _____
Home Address _____City _____ State_____ Zip _____
Parent or Guardian: Home Phone _____ Cell Phone_____
Name of Father _____Name of Mother_____
Father Employer _____Occupation _____ Work Phone_____
Mother Employer _____ Occupation _____ Work Phone_____
Person to contact for emergency _____ Relationship_____ Phone _____
Other family members who are patients in our office: _____
Whom may we thank for referring your child to our office? _____

Responsible Party Information

Name _____ Relationship to Patient _____
Address _____City _____ State _____ Zip _____
Home Phone _____Date of Birth _____Social Security # _____
Employer _____Address _____
Business Phone _____ Cell Phone _____

Dental Insurance Information

Primary Ins. Name of Policy Holder _____Date of Birth _____
Social Security # _____ NAME OF EMPLOYER _____
Dental Insurance Co. _____ Group # _____ Insurance ID#_____
Address _____ City _____ State _____Zip _____
Effective Date _____ Insurance Phone # _____

Secondary Ins. Name of Policy Holder _____Date of Birth _____
Social Security # _____ NAME OF EMPLOYER _____
Dental Insurance Co. _____ Group # _____ Insurance ID#_____
Address _____ City _____ State _____Zip _____
Effective Date _____ Insurance Phone # _____

I grant the right to Philip E. Strevey, DDS, FAGD to release information about my child's dental treatment to third party payors and/or health professionals. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

X_____ Date: _____
Signature of Parent or Responsible Party

Is this your child's first visit to the dentist? Yes ☐ No ☐ If no, date of last dental visit: _____

Reason: _____ Name of Dentist _____ Location _____

Has your child had a toothache recently? Yes ☐ No ☐

Has your child had any injuries to the teeth, due to falls or blows? Yes ☐ No ☐ If yes, please explain

Is either parent afflicted with any condition affecting the teeth? Yes ☐ No ☐ If yes, please explain

Has your child ever had any unfavorable dental experiences? Yes ☐ No ☐ If yes, please explain

CHILD'S MEDICAL HISTORY

Name of Child's Physician: _____ Physician phone #: _____

Date of child's last physical examination: _____

Is your child in good health? Yes ☐ No ☐ If no, please explain

Is your child under medical care now? Yes ☐ No ☐ If yes, please explain

Is your child receiving any medication now? Yes ☐ No ☐ If yes, list medication and explain the reason(s):

Is your child taking vitamins or a nutritional supplement? Yes ☐ No ☐ If yes, please list

Does your child receive fluoride supplements? Yes ☐ No ☐ If yes, please list dosage _____

Has your child taken any antibiotics recently? Yes ☐ No ☐ If yes, please list antibiotic and explain reason:

List any serious operations or illnesses your child has had:

Please mark with an "x" if your child has or has had any of the following:

☐ Rheumatic Fever	☐ Nausea	☐ Asthma	☐ Kidney Disease
☐ Heart trouble or mummer	☐ Brain Damage	☐ Epilepsy	☐ Hepatitis
☐ Jaundice or Liver problems	☐ Anemia	☐ Sinusitis	☐ Hayfever
☐ Abnormal Blood Pressure	☐ Diabetes	☐ Bleeding Problems	☐ Radiation Therapy
☐ Convulsions, seizures or fainting	☐ Dizziness	☐ Other Condition(s) not listed:	

PLEASE LIST ALL ALLERGIES:

How we can best assist your child in attaining and maintaining excellent oral health for their lifetime?

What are your oral health care goals for your child?

***I verify that the above personal, medical, and dental information is correct.**

Parent/Guardian Signature: _____

Relationship to Patient: _____ Date: _____

You have my consent to take the necessary x-rays when I am <u>not</u> present during my child's appointment.

Parent/Guardian Signature _____ Date: _____ Child's Name _____

To comply with HIPAA regulations and protect your privacy, completed and signed health forms cannot be returned by email but must be returned by fax, postal mail, or in person preferably prior to day of appointment. Thank you. 9/2/08