Nadim
Jubran
Dentistry

Child's History & Information

Child's name ______________________ Age ________ Birthdate ______________

Home Address __________________________________ Phone ______________

School Attending __________________ Child's nickname ________________

Child's Physician ____________________ Referred By ___________________

Parents' Names—Father __________________ Mother ______________________

Business address (father) ________________________ Phone ______________

Occupation (father) ____________________ Employed by _________________

Business address (mother) _______________________ Phone ______________

Occupation (mother) ____________________ Employed by _________________

Person financially responsible _____________________ Relationship __________

Insurance Carrier ____

Does the child have a history of any of the following: Please circle

Sensitivity or allergy to anything , measles, mumps, chicken pox, smallpox, tonsillitis, brain injury, skin diseases, heart trouble, rheumatic fever, anemia, asthma, ear trouble, eye trouble, tuberculosis, epilepsy, bleeding disorders, diabetes, kidney or liver involvement

Please explain any circled items ____

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Date of child's last dental care ________________ last x-rays taken ______________

List any medication child is taking _____________________________________

Is child under medical care? _______ Reason _________________________

I, the undersigned, give consent to agreed upon dental services and use of appropriate methods in behalf of (child's name) ____________________

Signed ________________________ Date ________________________