Patient History Form

Date: ______________ Chart #: ________________

Last Name: _________ First Name: ___________ Sex: F__ M__ Birth Date: __________

Address: _________________________ City: ____________ Postal Code: ____________

Phone: _____________ Cell Phone: _____________ E-Mail: ________________

PHN #: __________________ Status #:________________________________

Referred by: _________________________

Dental Insurance Information:

Father's Name: _____________ Birth Date: ______________

Mother's Name: _____________ Birth Date: ______________

Medical History: (Please check if patient has had any of the following)

- Heart Murmur
- Heart Disease
- Diabetes
- Hepatitis
- HIV Positive
- Asthma
- Tuberculosis
- Convulsions
- Emotional Disorders
- Cancer
- Autism
- Liver Disease
- Blood Disorders
- Bleeding Problems
- Kidney Disease
- Premature Birth
- Vision Problems
- Hearing Problems
- Learning Disability
- Epilepsy
- Eczema
- Blood Transfusion
- Meningitis
- Allergies (Food, Medication) Please List: ___________

Does your child have a health problem? Yes: __ No: __

Has your child been hospitalized? Yes: __ No: __

Does your child take any medicines? Yes: __ No: __

If yes, what kind? _______________________

Has your child been to a dentist? Yes: __ No: __

I, _______________________________________, being the (guardian) (self) of the above named patient hereby, give consent to Dr. Timothy/Isaac/Samuel Tam to perform treatments, operations, sedations and anesthesia that may be necessary to maintain optimum oral health.

Date: __________ Signature: ________________ Witness: __________________

Optional:

I hereby consent to the participation in taking of photographs and video for the patient above for educational purposes.

Date: __________ Signature: ________________ Witness: __________________