Dr. Scott Solow
Dr. John Horchos
Dr. Stephen Cohen

607 Chestnut St. Philadelphia, PA 19106 215-925-6251
7847 Old York Road, Elkins Park, PA 19027 215-635-5560

PATIENT INFORMATION FORM

Please complete this form as accurately as possible.This will help us provide the best possible health service for you and your child. This information form becomes part of our permanent records and will be held in strict confidence. If you are unable to complete this form by yourself, please ask for assistance. Thank you.

PERSONAL

Patient's name_____ Nickname_____

Date of birth_____ Age of patient_____ Years_____ Months_____ Sex: Male ( ) Female ( )

Home address_____ Zip_____
City State

Name of school _____

Telephone numbers: Home_____ Legal Guardian 1 Cell:_____ Legal Guardian 2 Cell:_____

Home E-mail:_____Whom may we thank for referring you to us? _____

Legal Guardian 1:_____ SS#_____ DOB_____ Occupation_____

Legal Guardian 2 :_____ SS#_____ DOB_____ Occupation_____

Legal Guardian 1 Dental Insurance Co._____ Employer_____

Legal Guardian 2 Dental Insurance Co._____ Employer_____

Brother's' and Sisters' Names and Ages _____

Name and address of Physician (Routinely Visited) _____

DENTAL AND MEDICAL HISTORY: (Please circle YES or NO where indicated)

1) Has the patient had any unusual or unpleasant experiences in a dental or medical office?..... **YES** **NO**
2) Has the patient had any injuries to the face, mouth or teeth?..... **YES** **NO**
3) What is the chief concern regarding the patient's oral health?_____
4) Has the child been in a hospital or had surgery?..... **YES** **NO**
5) Is the child currently taking any medication?..... **YES** **NO**
6) Does the child have any abnormal behavior?..... **YES** **NO**
7) Were there any problems during pregnancy, delivery or during the child's first year of life?..... **YES** **NO**
8) Has the child had any unusual reaction or allergy to medications, such as penicillin, aspirin, or local anesthetics?..... **YES** **NO**
9) Does the child have a history of:

Excessive or Prolonged Bleeding…..	**YES**	**NO**	Cerebral Palsy……	**YES**	**NO**
High Blood Pressure……	**YES**	**NO**	Sickle Cell Disease or Trait..……	**YES**	**NO**
Kidney Disease……	**YES**	**NO**	Heart trouble……	**YES**	**NO**
Diabetes……	**YES**	**NO**	Asthma..……	**YES**	**NO**
Tuberculosis……	**YES**	**NO**	Liver Disease..……	**YES**	**NO**
Behavior Problems……..	**YES**	**NO**	High Fevers……	**YES**	**NO**
Cancer or Tumors……	**YES**	**NO**	Anemia……	**YES**	**NO**
Speech Problems……	**YES**	**NO**	Hepatitis……	**YES**	**NO**
Hearing Problems……	**YES**	**NO**	Nutritional Problem……	**YES**	**NO**
Birth Defects……..	**YES**	**NO**	Convulsions (Seizures)……	**YES**	**NO**
Heart Murmur……	**YES**	**NO**	Any special problem not listed above?.....	**YES**	**NO**
AIDS or AIDS Virus carrier……..	**YES**	**NO**	X-Ray Treatment……	**YES**	**NO**

10) Please describe any current medical treatment, including drugs, pending surgery, recent injuries or any other information the doctor should be aware of:

11) Female patients: Has menstruation begun?..... **YES** **NO**
12) Describe the child's learning process for his/her age (circle one): slow average advanced
13) Childs' Interests, hobbies or pets _____
14) If there is any other information that you believe would be helpful to us, please comment:

Consent for Treatment

I, being the (father) (mother) (guardian) of the above named child, hereby give consent to Children's Dental. & Orthodontic Associates to perform the dental treatment necessary to correct oral problems present as well as express consent to utilize the behavior management techniques approved and recommended by the American Academy of Pediatric Dentistry, (i.e., Tell, Show, Do Behavior Modification). I will inform Children's Dental & Orthodontic Associates of any new medical problems or changes that may occur in the future.

You also give us permission to use your signature on file for your insurance forms.

Signed_____ Date_____