DAREL MOSS
DDS & ASSOC.

Pediatric Patient

Patient Name: _____ Date _____
Age _____ Birthdate _____ School _____ Grade _____
Parent's/Guardian Names _____
Home Address _____ City _____ State _____ Zip _____
Phone(home) _____ Phone(mobile) _____ Email _____
Mr./Ms. Employed By _____ Mr./Ms. Employed By _____
Occupation _____ City _____ Occupation _____ City _____
Business Phone _____ Business Phone _____
Parent's Martial Status ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Single
Person Responsible for Account _____ SSN _____
Address _____ Phone Number _____
Dental Insurance _____ Subscriber DOB _____
Subscriber ID No. _____ Group No. _____
Other Children: Names and Ages _____
Referred By: _____

Pediatric Medical History

Physician/Pediatrican _____ Address _____ Phone _____
Has patient had any history of the following:

Allergies	☐ Yes ☐ No	Allergy to Medications	☐ Yes ☐ No
AIDS (HIV positive)	☐ Yes ☐ No	Autism Spectrum Disorder	☐ Yes ☐ No
Behavioral Challenges	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Bleeding Tendencies	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Easy Bruising	☐ Yes ☐ No	General Anesthesia	☐ Yes ☐ No
Hospitalization	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart Condition (Is premed required)	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Liver or Kidney Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No

Comments _____
Is Patient Presently Taking Medication or Under Medical Care ☐ Yes ☐ No
Last Physical Exam _____

Pediatric Dental History

Has patient ever had:

Previous Dental Cleaning / Exam	☐ Yes ☐ No	X-Rays – Date of Last:	☐ Yes ☐ No
Topical Fluoride	☐ Yes ☐ No	Dental Treatment	☐ Yes ☐ No

Has either parent or any children had a history of:

Orthodontic Problems or Treatment	☐ Yes ☐ No
Congenitally Missing Teeth	☐ Yes ☐ No