Patient Information Record
(Child)

Patient's Full Name	Preferred Name		Age
Address	City	State/Zip	Date of Birth
How long at this address? ☐ Rent ☐ Own	School	Grade	Home Phone
Father's Name	SSN	Cell Phone	Work Phone
Occupation	Employed By	How long?	Date of Birth
Mother's Name	SSN	Cell Phone	Work Phone
Occupation	Employed By	How long?	Date of Birth
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Responsible Party	Email	
Siblings: ☐ Yes ☐ No	Name/Age	Name/Age	Name/Age
	Name/Age		
Responsible Party	Relationship to patient	SSN	
Address	City	State/Zip	Home Phone
Employed By	How long?	Cell Phone	Work Phone
Driver's License Number	Insurance Company	ID#	
Insured's Name	Relationship to patient	D.O.B.	SSN
I authorize Dr. Oakes to file insurance benefits on my behalf. Signature:	I have received and read the HIPPA acknowledgement Initial:		
Dentist	Physician	Referral by	

Medical History - *Have you ever had (or have) any of the following: (please check)*

☐ Heart Problem ☐ Epilepsy ☐ Arthritis ☐ Emotional Problems
☐ Rheumatic Fever ☐ Hepatitis/Jaundice ☐ Radiation Therapy ☐ Prolonged Bleeding
☐ Bone Disorders ☐ HIV/Aids ☐ Allergies/Asthma ☐ Fainting or Dizziness
☐ Tuberculosis ☐ Diabetes ☐ Speech/Hearing Problems ☐ Frequent Headaches
☐ Kidney Involvement ☐ Major Operation ☐ Blood Transfusion
☐ Endocrine Problems ☐ Anemia ☐ Other

Dental History - *Have you ever had (or have) any of the following: (please check)*

☐ Injury to face/teeth, jaws, head ☐ Clenching/grinding teeth ☐ Extraction of teeth ☐ Pain in jaw joint or muscles
☐ Thumb/finger sucking ☐ Periodontal disease ☐ Extra or missing permanent teeth ☐ Jaw joint locked or out-of-joint
☐ Mouth Breathing ☐ Root canal treatment ☐ Clicking/popping in jaw ☐ Other dental problems

Is patient presently under the care of a physician? ☐ Yes ☐ No If so, for what? ______________________

List all medicines (including herbal supplements) patient is currently taking ______________________

List all drugs or medicines to which patient has had a reaction or is allergic ______________________

Have tonsils and/or adenoids been removed? ☐ Yes ☐ No What age? ______________________

Signature	Date