Child/Minor

(Under 18 years old)

Medical History

Today's Date_____

Name_____ I prefer to be called: _____ Birth date _____SS#_____

Address_____City_____State_____Zip_____

Phone # Mobile (____)_____ Home (____)_____

Parent/ Guardian_____Relationship to patient (Circle one)
Mother Father Step-parent guardian grandparent

Address & Phone#_____

Email address_____ (only for appointment reminders)

Emergency contact_____Phone#_____Relation:_____

Physician's Name: _____ Phone #_____ Date of last visit: _____

Why have you come to the dentist today? _____ Is patient currently in pain? Yes No

Pharmacy Name_____ Location_____ Phone Number_____

Medications:

Please list any and **ALL** Medications Patient is taking including prescription, over the counter, herbal, vitamins and minerals, weight loss aids, cold or allergy medicine, pain medicine, etc:

_____
_____
_____
_____

Girls: Are you taking Birth Control Pills? Yes No
…Hormone Replacement? Yes No

Are you Pregnant? Yes No Week #_____
Are You Nursing? Yes No

Do you or have you ever had any of the following diseases or conditions?
(**Please circle either Y or N for each condition**)

Y	N	Diabetes
Y	N	High or Low Blood Pressure
Y	N	Heart Attack
Y	N	Endocarditis
Y	N	Rheumatic or Scarlet Fever
Y	N	Congenital Heart Defect
Y	N	Mitral Valve Prolapse
Y	N	Pacemaker
Y	N	Have you been advised to take antibiotics before dental appts?
Y	N	Heart Surgery
Y	N	Artificial Heart Valve replacement
Y	N	High Cholesterol
Y	N	Stroke
Y	N	Blood Transfusion
Y	N	Hemophilia/ Abnormal Bleeding
Y	N	Anemia
Y	N	HIV~AIDS

Y	N	Shingles
Y	N	Skin conditions (Psoriasis, etc)
Y	N	Fever Blisters/ Cold Sores
Y	N	Drug/ Alcohol Abuse
Y	N	Hepatitis
Y	N	Venereal Diseases/ STD's
Y	N	Difficulty Breathing, Shortness of Breath
Y	N	Asthma
Y	N	Arthritis (Osteo or Rheumatoid)
Y	N	Cancer/ Chemotherapy
Y	N	Radiation Treatment
Y	N	Glaucoma or Cataracts (eye problems)
Y	N	Sinus Problems
Y	N	Tuberculosis (TB)
Y	N	Severe/ Frequent Headaches/Migraines
Y	N	Emphysema/ Bronchitis
Y	N	Psychiatric Problems
Y	N	Brain or Neural conditions
Y	N	Meningitis viral or bacterial
Y	N	Artificial Bones/ Joints (knee, hip etc)
Y	N	Tumors
Y	N	Kidney Problems
Y	N	Epilepsy/Seizures/Fainting spells
Y	N	Ulcers/ Colitis/GERD
Y	N	Hospitalized for any reason
Y	N	Osteoporosis

Please list any pertinent information and serious medical conditions patient has ever had and explain_____

_____

_____

Allergies:

Y	N	Penicillin	Y	N	Dental Anesthetics (Novocain)
Y	N	Aspirin	Y	N	Sulfa drugs
Y	N	Tetracycline	Y	N	Latex
Y	N	Codeine	Y	N	Other

Please list any others not mentioned above including food allergies:_____

_____

_____

Does patient smoke? Y N Pks per day_____# of Years_____

Does patient use any other tobacco products? (Pipe, cigars, snuff, dip, chew, vaping) Y N Amount Daily_____

I acknowledge that the information given today is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence as outlined by HIPAA guidelines. I am aware it is my responsibility to inform the office immediately of any and all changes in my medical status. I also understand that every insurance policy is different and that I owe the total amount charged to my account regardless of insurance coverage. Any estimates of insurance coverage by Dr. Elias' office are done as a courtesy and are not binding and only my insurance company is able to make a final determination of benefits for my treatment.

X_____

Date:_____.

Signed by patient or parent/guardian of minor patients

INSURANCE COVERAGE

Insurance Company_____

Address_____

City, State, Zip_____

Group Number_____ Phone Number _____

Employer _____

Subscriber's Name_____ID #_____