

Wolfpack Dental

9321 N. Haggerty Rd., Plymouth, MI 48170 • (734) 455-4070

PATIENT HEALTH RECORD

PATIENT'S NAME _____ DATE _____
ADDRESS _____ PATIENT'S BIRTHDATE _____
CITY, STATE, ZIP _____ FATHER'S BIRTHDATE _____
PHONE # _____ MOTHER'S BIRTHDATE _____

MOTHER'S NAME _____ SOCIAL SECURITY # _____
PLACE OF EMPLOYMENT _____ ADDRESS _____
BUSINESS PHONE # _____ CELL _____ PRESENT, POSITION _____
LENGTH OF EMPLOYMENT _____ CONTRACT ID # _____
DENTAL INSURANCE CO. _____ GROUP/POLICY/UNION _____
EMAIL _____

FATHER'S NAME _____ SOCIAL SECURITY # _____
PLACE OF EMPLOYMENT _____ ADDRESS _____
BUSINESS PHONE # _____ CELL _____ PRESENT, POSITION _____
LENGTH OF EMPLOYMENT _____ CONTRACT ID # _____
DENTAL INSURANCE CO. _____ GROUP/POLICY/UNION _____
EMAIL _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED _____

PHONE # _____ RELATIONSHIP TO PATIENT _____

WHO SHALL WE THANK FOR REFERRING YOU _____

WHO WILL PAY THIS ACCOUNT _____

ADDRESS _____ PHONE _____

UNDER 12

IF CHILD IS UNDER 12, PLEASE FILL OUT THIS SECTION

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE FICTIONAL CHARACTER _____

AUTHORIZATION TO PAY BENEFITS TO DENTIST:

I HEARBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE INSURANCE BENEFIT OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DATE OF LAST DENTAL VISIT _____ FOR WHAT SERVICE _____

- YES NO CHILD'S ATTITUDE TO DENTISTRY _____
- HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS _____
 - ANY UNHAPPY DENTAL EXPERIENCES _____
 - ANY INJURIES TO THE MOUTH, TEETH, HEAD _____
 - ANY THUMBSUCKING, NAIL BITING, MOUTH BREATHING, BOTTLE/PACIFIER HABITS _____
 - HAVE ANY TEETH BEEN LOST OR REPLACED _____
 - _____ DO YOU ASSIST CHILD _____
 - _____ HOW OFTEN IS TOOTH BRUSHING DONE _____
 - _____ HOW OFTEN IS FLOSS USED _____ IS FLUORIDE TAKEN IN ANY FORM _____
 - ORTHODONTIC APPLIANCES WORN NOW OR EVER BEFORE _____
 - DO YOU DESIRE COMPLETE DENTAL SERVICE FOR CHILD _____

HEALTH HISTORY

CHILD'S PHYSICIAN _____ ADDRESS _____ PHONE _____

DATE OF LAST EXAM _____ RESULTS _____

- YES NO
- IS CHILD UNDER CARE OF PHYSICIAN NOW _____
 - IS CHILD RECEIVING ANY MEDICATION OR DRUGS _____
 - IS THERE ANY EXCESSIVE BLEEDING WHEN CUT _____
 - HAS THERE EVER BEEN A HEART MURMUR DIAGNOSED _____
 - HAS CHILD EVER BEEN HOSPITALIZED _____
 - HAS CHILD EVER HAD SURGERY _____
 - IS THERE ANY ALLERGY TO PENICILLIN OR OTHER DRUGS _____
 - ARE THERE OTHER ALLERGIES: FOOD, POLLEN, ANIMALS, DUST, ETC. _____
 - ARE THERE ANY EMOTIONAL PROBLEMS _____

HAS CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING:

- | | | | | |
|--------------------|-----------------|------------------|---------------------|---------------------|
| ___ Chronic Sinus | ___ Hearing | ___ Mastoid | ___ Rheumatic Fever | ___ Anemia |
| ___ Asthma | ___ Convulsions | ___ Heart | ___ Measles | ___ Thyroid |
| ___ Bladder | ___ Diabetes | ___ Kidney | ___ Mononucleosis | ___ Tuberculosis |
| ___ Cerebral Palsy | ___ Epilepsy | ___ Liver | ___ Mumps | ___ A.I.D.S. |
| ___ Chicken Pox | ___ Fainting | ___ Malignancies | | ___ H.I.V. Positive |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

May we request release of your child's medical records for our reference? _____ Yes No

This information was discussed with and given by _____

Relationship to child _____