ROBERT A. DEGANO, D.M.D.
JING ZHAO , D.D.S.

CHILD'S HISTORY & INFORMATION

(confidential information for our files)

PLEASE PRINT CLEARLY

Child's Name _____ Age _____ Birth date _____
Last First Middle

Home Address _____ Phone _____
Street City State Zip

School Attending _____ Grade _____ Child's Nickname _____

Child's Physician _____ Phone _____

Occupation, Father _____ Employed by _____

Business address _____ Phone _____
Street City State Zip

Occupation, Mother _____ Employed by _____

Business address _____ Phone _____
Street City State Zip

Person Financially Responsible _____ Relationship _____
Last First Middle

Dental Insurance? _____ Hospitalization Insurance? _____
Company

Whom may we thank for referring you _____

Does your child have any history of the following?

(If yes, please circle the condition)

measles - mumps - chickenpox - smallpox - tonsilitis - heart trouble - heart murmur - rheumatic fever - anemia - bleeding disorders - allergies - asthma - skin diseases - ear trouble - eye trouble - brain injury - epilepsy - seizures - TB - diabetes - kidney or liver involvement - any other general illnesses - speech problems

Give date of child's last medical exam _____

Give date of child's last dental exam _____

Please indicate (✓)	Yes	No
Have full mouth x-rays ever been taken?	___	___
Has your child ever had unfavorable reactions from previous medical or dental care?	___	___
Is the child sensitive or allergic to any food?	___	___
_____ medication ?	___	___
If yes, to what _____		
Taking any medication now?	___	___
What is your child's weight?	___	___
Under medical care now?	___	___
Any previous hospitalizations?	___	___
If yes, why? _____		

Remarks _____

I, the undersigned, do give consent to agreed upon dental services, and use of appropriate methods thereto, in behalf of

_____ Signed _____ date _____
Print child's name Print your name signature of parent or legal guardian

REMARKS Abberations Growth and Development