Nadim Jubran Dentistry

Child's History & Information

Child's name_____Age_____Birthdate_____

Home Address_____Phone_____

School Attending_____ Child's nickname_____

Child's Physician_____Referred By_____

Parents' Names—Father_____Mother_____

Business address (father)_____Phone_____

Occupation (father)_____Employed by_____

Business address (mother)_____Phone_____

Occupation (mother)_____Employed by_____

Person financially responsible_____Relationship_____

Insurance Carrier_____

Does the child have a history of any of the following: Please circle

Sensitivity or allergy to anything , measles, mumps, chicken pox, smallpox, tonsillitis, brain injury, skin diseases, heart trouble, rheumatic fever, anemia, asthma, ear trouble, eye trouble, tuberculosis, epilepsy, bleeding disorders, diabetes, kidney or liver involvement

Please explain any circled items_____

_____

Date of child's last dental care_____last x-rays taken_____

List any medication child is taking _____

Is child under medical care? _____ Reason_____

I, the undersigned, give consent to agreed upon dental services and use of appropriate methods in behalf of (child's name) _____

Signed_____Date_____