JOHNSON AND TRANG DENTAL P.C.

9321 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 _____
BUISNESS 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 _____
BUISNESS 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 THUMSUCKING, NAIL BITING, MOUTH BREATHING, BOTTLE/PACIFIER HABITS _____

□ □ HAVE ANY TEETH BEEN LOST OR REPLACED _____

HOW OFTEN IS TOOTH BRUSHING DONE _____ DO YOU ASSIST CHILD _____

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 _____