KIMBERTON DENTAL ASSOCIATES – Pediatric Patient Questionaire

Dr. Nhat-Khai Do – Dr. Pei Ting Sawyer

I. Patient Information:

Patient Name: ______________________________ SS#: _______________ DOB: ______________

Preferred name: ___________________________ Favorite pet(s): ______________________________

II. Parents/ Legal guardian/ Person responsible for child's account:

Mr. / Mrs. _________________________________ SS#: _______________ DOB: ______________

Male ☐ Female ☐ Other ☐ Single ☐ Married ☐ Divorced ☐

Address: ____

____

Contact phone number: ______________________ Alternative contact number: ___________________

Name of the insurance company for the child: ____

Signature: ____ Today's date: ______________________

II. Medical History:

	Yes	No
1. Is the patient in good health? ____	☐	☐
2. Is the patient sensitive or allergic to anything? ___________________________	☐	☐
3. Has the patient experienced any unfavorable reaction from any previous dental or medical care? _____________________________________	☐	☐
4. History of heart trouble, rheumatic fever, epilepsy, diabetes, bleeding, or mental disorders? (please circle) ______________________________	☐	☐

Please use reverse side for any additional information regarding patient's history.

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Dr. Nhat-Khai Do – Dr. Darry Ma

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