



Today's date:		PCP:	
NEW PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	
		<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:
<input type="checkbox"/> Yes <input type="checkbox"/> No			/ /
		Age:	Sex:
			<input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:	Home phone no.:
			()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.:	
		()	
How did you hear about us?			
Other family members seen here:			
EMAIL:			

INSURANCE/FINANCIAL INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:	
	/ /			()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.:	
				()	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			\$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:
			()
			Work phone no.:
			()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Singh to release any information required to process my claims.			
_____ Patient/Guardian signature		_____ Date	

PEDIATRIC MEDICAL HISTORY

CHILD'S FULL NAME:

Gender: Height: Weight: Date of last physical exam?	Has your child had a serious illness, operation or ever been hospitalized? Any complications during birth, premature birth, birth defects, syndromes or inherited conditions? Please list
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Please list all **medications** (prescription and over the counter), vitamins and diet/herbal supplements you are taking
(you can also provide a copy of medications)

Drug	Dose/ Frequency	Reason

Please mark (X) your response to indicate if you have or have not had any of the following diseases:

	Y	N		Y	N		Y	N
Is your child up to date on immunizations?			AIDS/HIV infection			Hepatitis, jaundice or liver disease		
Cerebral palsy/brain injury Hydrocephaly or placement of stent			Arthritis or Scoliosis			Epilepsy		
Sinusitis, Chronic adenoid/tonsil infections			Autoimmune disease			Seizures		
Sleep apnea, mouth breathing, excessive gagging			Rheumatoid arthritis			Neurological disorders Specify (if yes):		
Damaged heart valves			Asthma, wheezing or breathing problems			Precocious puberty or hormone problems		
Heart murmur			Frequent colds, cough or pneumonia			Mental health disorder/ behavioral, communication or psychiatric problems/treatment		
Low blood pressure			Cystic Fibrosis			Recurrent infections: Type of infection:		
High blood pressure						Bladder or Kidney Problems		
Other congenital heart defects If yes, which type:			Rash/hives, eczema or skin problems			Abuse (physical, emotional, sexual) or neglect		
Artificial (prosthetic) heart valve			Tuberculosis			Autism/autism spectrum disorder		
Previous infective endocarditis			Cancer			Persistent swollen glands in neck		
Damaged valves in transplanted heart			Chemotherapy or Radiation treatment			Severe headaches/migraines		
Congenital heart disease (CHD) Unrepaired, cyanotic CHD Repaired (completely) last 6 mo Repaired CHD with residual defects			Eating Disorder Malnutrition Hyper/hypoglycemia			Has a physician or previous dentist recommended that you take antibiotics prior to you dental treatment? If yes, for what reason:		
Severe or rapid weight loss			Diabetes Type I or II Is Diabetes controlled?			Frequent exposure to tobacco or smoke		
Rheumatic fever			Gastrointestinal disease			Lactose Intolerance		
Anemia, sickle cell disease or blood disorder			G.E reflux/ heartburn			Attention deficit/hyperactivity disorder (ADD/ADHD)		
Hemophilia or abnormal bleeding?			Thyroid Disease			Mononucleosis tuberculosis (TB)		
Blood transfusion			Pituitary Gland Problems?			Cytomegalovirus (CMV)		

ALLERGIES:

- Antibiotics (eg. Penicillin), if so which one?
 Latex Dental Anesthetics Food Aspirin Anti-inflammatories Sulfa Drugs Codeine or other narcotics
 Metals Hay fever/ seasonal Barbiturates, sedatives Other allergies:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian signature

Date



Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse To Sign This Acknowledgement

I, _____, have viewed and read a copy of this office's Notice of Privacy Practices.

Relationship to Child Patient

Please Print Name

Signature

Date