WEST ANNAPOLIS FAMILY DENTISTRY, LLC
101 RIDGELY AVENUE SUITE 20
ANNAPOLIS, MARYLAND 21401
Annapolis (410) 263-3700

MINOR'S HISTORY AND INFORMATION

Child's Name _____ Nick Name _____

Home Address _____ Phone No. _____

Social Security No._____ Date of Birth _____

School Attending _____

Child's Physician _____ Phone No. _____

Parent's Name _____ Referred By _____
Father's Employer/Address/Phone No._____
_____
Mother's Employer/Address/Phone No._____
_____
Person Financially Responsible _____
Dental Insurance Company _____
ID No. _____ Group No. _____

Does the child have any history of the following: (Circle if Yes)
Chicken Pox, Small Pox, Tonsillitis, Brain Injury, Anemia, Skin Diseases, Heart Trouble, Rheumatic Fever, Ear Trouble, Asthma, Eye Trouble, Allergies, Tuberculosis, Epilespy, Bleeding Disorders, Kidney or Liver Involvement.
Please Circle Yes or No
Have full mouth x-rays ever been taken? Yes or No
Has the child ever had any unfavorable reactions
from previous medical or dental care? Yes or No
Is the child Sensitive or allergic to any food
Or Medication? Yes or No
Taking any Medication now? Yes or No
Under Medical care now? Yes or No
If Yes, State Reason_____
Date of child's last dental exam_____
Remarks _____
I, Understand, Do give consent to agree upon dental services and use appropriate methods thereto, in behalf of _____.
Child's Name
Date _____ Parent/Guardian _____