ELIZABETH A. BELL, DDS.
NICHOLAS R. THOMPSON, DMD.
525 High School Road NW Bainbridge Island, WA 98110
(206) 842-4794

DATE: _____

CHILD'S NAME: _____ SCHOOL: _____ BIRTH DATE: _____

ADDRESS: _____

_____ PHONE #: _____

FATHER'S NAME: _____ S.S.#: _____ BIRTH DATE: _____

EMPLOYED BY: _____ BUS. PHONE: _____

INSURANCE: _____ GROUP #: _____

MOTHER'S NAME: _____ S.S#: _____ BIRTH DATE: _____

EMPLOYED BY: _____ BUS. PHONE #: _____

INSURANCE: _____ GROUP # : _____

REFERRED BY: _____

MEDICAL HISTORY

IS CHILD IN GOOD HEALTH?.....YES NO

- HAS THERE BEEN ANY CHANGE IN THE CHILD'S HEALTH THE PAST YEAR?.....YES NO
- CHILD'S LAST PHYSICAL EXAMINATION WAS ON _____
- IS CHILD NOW UNDER THE CARE OF A PHYSICIAN?.....YES NO
  - NAME OF CHILD'S PHYSICIAN _____
- HAS THE CHILD HAD ANY SERIOUS ILLNESS OR OPERATION?.....YES NO

HAS THE CHILD BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST 5 YEAR?.....YES NO

- IF SO, WHAT FOR? _____

HAS THE CHILD HAD SURGEY, X-RAY OR DRUG TREATMENT FOR TUMOR GROWTH OR OTHER CONDITION?.....YES NO

- IS THE CHILD TAKING ANY DRUGS OR MEDICATION?.....YES NO
  - IF SO, WHAT? _____
- IS THE CHILD TAKING ANY OF THE FOLLOWING:

1. ANTICOAGULANTS (BLOOD THINNERS).....YES NO
2. ANTIBOTICS OR SULFA DRUGS.....YES NO
3. MEDICINES FOR HIGH BLOOD PRESSURE.....YES NO
4. CORTISONE (STERIODS).....YES NO
5. TRANQUILIZERS.....YES NO
6. ANTIHISTAMINES.....YES NO
7. ASPRIN.....YES NO
8. INSULIN, TOLBUTAMID (ORINASE), OR SIMILAR DRUG.....YES NO
9. DIGITAILS OR DRUGS FOR HEART TROUBLE.....YES NO
10. NITROGLYCERIN.....YES NO
11. OTHER _____

- DOES CHILD HAVE OR HAS HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

1. DAMAGED HEART VALVES OR ARTIFICIAL HEART VALVES, HEART MURMUR.....YES NO
2. CONGENTIAL HEART LESIONS.....YES NO
3. HEART TROUBLE, HEART ATTACK.....YES NO
4. RHEUMATIC FEVER.....YES NO
5. HIGH BLOOD PRESSURE.....YES NO
6. ALLERGIES.....YES NO
7. SINUS TROUBLE.....YES NO
8. RESPIRATORY PROBLEMS (ASTHMA, EMPHYSEMA, CHRONIC BRONCHITIS, TB).....YES NO
9. SEIZURES.....YES NO
10. DIABETES.....YES NO
11. HEPATITIS, JAUNDICE, OR LIVER DISEASE.....YES NO
12. ARTHRITIS, INFLAMMATORY RHEUMATISM.....YES NO
13. ARTIFICIAL JOINTS.....YES NO
14. STOMACH ULCERS.....YES NO
15. MULTIPLE SCLERIOSIS.....YES NO
16. LOW BLOOD PRESSURE.....YES NO
17. EPILEPSY.....YES NO
18. PSYCHIATRIC PROBLEMS / MEDICATIONS.....YES NO
19. CANCER.....YES NO
20. AIDS OR OTHER IMMUNOSUPPRESSIVE DISORDERS.....YES NO
21. ABNORMALLY LONG BLEEDING TIME OR BRUISE EASILY.....YES NO
22. BLOOD TRANSFUSION.....YES NO
23. BLOOD DISORDERS, ANEMIA.....YES NO

- IS CHILD ALLERGIC OR HAS CHILD REACTED ADVERSELY TO:

1. LOCAL ANESTHETICS (NOVACAINE).....YES NO
2. PENICILLIN OR OTHER ANTIBIOTICS.....YES NO
3. SULFA DRUGS.....YES NO
4. BARBITURATES, SEDATIVES, OR SLEEPING PILLS.....YES NO
5. ASPRIN.....YES NO
6. IODINE.....YES NO
7. CODEINE OR OTHER NARCOTICS.....YES NO
8. SULFITIES.....YES NO
9. OTHER_____

- DOES CHILD HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT? IF SO, EXPLAIN:

_____

_____

- WHEN WAS CHILD LAST SEEN BY A DENTIST?_____
- NAME OF PREVIOUS DENTIST_____
- HAS CHILD HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT? IF SO, EXPLAIN_____

_____

_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENTS OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES. THIS RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT, DIRECTLY TO THE DOCTOR, OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE_____