Michael Kasselian, D.D.S
Patient Information and Health History

Child's Name_____ Male /Female Birth Date:_____
First MI Last

Address_____ Town_____ Zip_____ Phone#_____-_____-_____

Parent's Name (**Father**)_____ Social Security#_____ Cell Phone#_____-_____-_____
Father's Occupation_____ Employer_____ Work Phone# _____-_____-_____
Father's Email:_____ Date Of Birth:_____
Parent's Name (**Mother**)_____ Social Security#_____ Cell Phone#_____-_____-_____
Mother's Occupation_____ Employer_____ Work Phone# _____-_____-_____
Mother's Email:_____Date Of Birth:_____

Who may we thank for referring you? _____
Names and Ages of other children?_____
Family Dentist_____Child's Physician_____ Phone#_____-_____-_____
Grade and Name of School Child Attends_____

Name of medications taken recently by your child (including vitamins)_____
Has your Child had any type of allergic reaction to any food, medicine, or other substances? Please describe below:
_____

Has your child ever been hospitalized?_____ If yes' give details:_____
Does your child have a heart murmur or heart defect?_____
If the patient had had any of the following diseases or conditions, please check one(s):

__Measles	__Diabetes	__Bleeding Problems	__AIDS or AIDS related complex
__Chicken Pox	__German or "3 day" Measles	__Asthma or Wheezing	__Skin Problems
__Mumps	__Hearing Difficulties	__Rheumatic Fever	__Bone and Joint Problems
__Scarlet Fever	__Speech Difficulties	__Kidney Disease	__Growth Abnormalities
__Pneumonia	__Emotional Difficulties	__Tuberculosis	__Whooping Cough
__Birth Defects	__Fainting or Dizziness	__Epilepsy or Seizures	__Broken Bones
__Poor Vision	__Sickle Cell Anemia	__Serious Accidents	__Liver disease or Hepatitis
__Anemia	__Removal of Tonsils or Adenoids	__Cancer	

___ THERE IS NO HISTORY OF PROBLEMS

Does your child have any of the following?: ____Autism _____ADD ____ PDD

What is your main reason for bringing your child today?_____
Is this the child's first dental visit?_____ If not, when was the last visit and for what reason?_____
Was Nitrous Oxide Used_____ Was local anesthetic used?_____
Was the child sedated?_____ Was the child restrained?_____
Were dental X-ray films taken of your child?_____ If yes, by whom?_____

Does your child have any of the following habits?
___Thumb Sucking __Mouth Breathing __Speech Problems __Pacifier
___Using the bottle __Tongue Thrusting __Grinding of the teeth

Has your child ever had any injury to the face or teeth?_____
Has Your child ever had an unfavorable reaction to local or general anesthesia?_____

How do you think your child will react to this visit:
__Very Poorly __Poorly __Well __Excellent __I don't know

I Give Consent for general treatment by Michael Kasselian, D.D.S:
Parent/Guardian

_____ _____
Signature Date Print Name Relationship to Child