Beth A. Loew, D.D.S.
2164 Riverside Drive
Columbus, Ohio 43221
(146) 487-0112

PATIENT INFORMATION FORM

CHILD INFORMATION

Name: ______________________________ ☐ Male ☐ Female Birth Date: _____ / _____ / _____
LAST FIRST MI

Home Address: ______________________________
APT / CONDO # CITY STATE ZIP

Referred By: ______________________________

Physician's Name: ______________________________ Physician's Phone: ( ) __________

With Whom does the patient live: ______________________________ Relationship: __________

PARENT INFORMATION

Mother's Name: ______________________________ Home Phone: ( ) __________ Cell #: __________

Address (if different): ______________________________
APT / CONDO # CITY STATE ZIP

SS # ______________________________ Birth Date: _____ / _____ / _____

Occupation: ______________________________ Work Phone: ( ) __________

Employer: ______________________________

Father's Name: ______________________________ Home Phone: ( ) __________ Cell #: __________

Address (if different): ______________________________
APT / CONDO # CITY STATE ZIP

SS # ______________________________ Birth Date: _____ / _____ / _____

Occupation: ______________________________ Work Phone: ( ) __________

Employer: ______________________________

EMERGENCY INFORMATION

Please list a local person to contact in an emergency (other than listed above).

Name: ______________________________ Relation: __________

Home Phone: ( ) ______________________________ Work Phone: ( ) __________

INSURANCE INFORMATION

Employer: ______________________________

Insurance Company Name: ______________________________

Phone: ( ) ______________________________ Policy Number: __________

Name of Insured ______________________________

Birth Date: _____ / _____ / _____ SS # __________

SECONDARY INSURANCE INFORMATION

Insurance Company Name: ______________________________

Phone: ( ) ______________________________ Policy Number: __________

over →

Medical / Dental History

Has your child had any of the following medical or dental conditions / problems?
Please mark the appropriate answers and fill in the blanks.

Medical History

☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Heart problems
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Bleeding problems
☐ Yes ☐ No Hemophilia

☐ Yes ☐ No Asthma
☐ Yes ☐ No Allergy to any drugs
☐ Yes ☐ No Allergy to latex or plastic

☐ Yes ☐ No Genetic Disorders
☐ Yes ☐ No Disabilities / Handicaps
☐ Yes ☐ No Hearing problems
☐ Yes ☐ No Vision problems

☐ Yes ☐ No Cancer / Radiation / Chemo
☐ Yes ☐ No Diabetes
☐ Yes ☐ No HIV / AIDS
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Kidneys / Liver problems
☐ Yes ☐ No Epilepsy / Convulsions
☐ Yes ☐ No Bone / Joint problems

☐ Yes ☐ No Hospitalizations
☐ Yes ☐ No Surgeries
☐ Yes ☐ No Other medical problems or conditions (Specify)

____
____
____

☐ Yes ☐ No Current medications (list)

____
____
____
____

Dental History

☐ Yes ☐ No Injuries to jaws or teeth
☐ Yes ☐ No Toothaches
☐ Yes ☐ No Abscesses (gum boils)
☐ Yes ☐ No Frequent mouth sores
☐ Yes ☐ No Bleeding gums

☐ Yes ☐ No Thumb / Finger sucking habit
☐ Yes ☐ No Lip / Tongue biting habit
☐ Yes ☐ No Clenching or grinding habit

☐ Yes ☐ No Flouridated water
☐ Yes ☐ No Flouride rinses / Supplements
☐ Yes ☐ No Teeth brushed daily
☐ Yes ☐ No Teeth flossed daily

☐ Yes ☐ No First visit to dentist (if no, date of last visit)

____

☐ Yes ☐ No Problems associated with previous dental work (list)

____
____

☐ Yes ☐ No Other dental problems or conditions (Specify)

____
____
____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

______________________________ ______________________________
Signature of parent or guardian Date

Office Use Only

Medical History Review & Update

I have reviewed the medical / dental information above with the parent / guardian and patient named herein.

Date	Signature	Date	Signature

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