

Talbot A. Sklar, D.D.S.

PATIENT INFORMATION

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Patient's Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ School \_\_\_\_\_  
Father's Address (If different than above) \_\_\_\_\_  
Mother's Address (If different than above) \_\_\_\_\_  
Hobbies, Pets, TV Shows \_\_\_\_\_ Referred by \_\_\_\_\_  
Other Children In Family (Names & Ages) \_\_\_\_\_  
Reason for this visit (Exam, Toothache, etc) \_\_\_\_\_  
Family Dentist \_\_\_\_\_ Date of last dental care \_\_\_\_\_  
Child's Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

PERSON (S) RESPONSIBLE FOR ACCOUNT

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_  
Father's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Father's Dental Insurance Carrier: \_\_\_\_\_ Group# \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_  
Mother's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mother's Dental Insurance Carrier: \_\_\_\_\_ Group# \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
Driver's License # \_\_\_\_\_

Name & Address To Which Statements Will Be Sent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Has your child any history of:

(IF YES PLEASE CIRCLE)

HEART CONDITION	BRAIN INJURY	JAUNDICE
MITRAL VALVE PROLAPSE	TUBERCULOSIS	FAINTING
RHEUMATIC FEVER	CONVULSIVE DISORDER	ASTHMA
HEART MURMUR	UNUSUAL BLEEDING	ANEMIA
KIDNEY/LIVER INVOLVEMENT	STOMACH TROUBLE	AIDS
PSYCHOLOGICAL DISORDER	DIABETES	HEPATITIS

Please circle YES or NO to the following questions:

Is there anything concerning your child's medical history which you feel may be important?	Yes	No
Is your child allergic to anything? (food, medicine, drugs, etc.)	Yes	No
Is your child taking any medications?	Yes	No
Has your child ever been hospitalized?	Yes	No
Was pregnancy and delivery Abnormal?	Yes	No
Were any drugs taken during pregnancy?	Yes	No
Has your child had unfavorable reactions from previous dental care?	Yes	No
Have you or your child ever received any blood transfusions or blood products?	Yes	No
Have you or your child been told that you have an infectious disease?	Yes	No

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS, PLEASE EXPLAIN BELOW