Children's Dental Surgery Center

1523 E March Lane Suite #A*Stockton, CA 95210

Patient Information

Last Name: _____ First Name: _____ MI: _____ Male [ ] Female [ ]

Date of Birth: _____ Age: _____ Social Security Number: _____ - _____ - _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: ( ) _____ Cell: ( ) _____ Other: ( ) _____

LANGUAGE SPOKEN:

( ) English ( ) Spanish ( ) Arabic ( ) Armenian
( ) French ( ) German ( ) Chinese ( ) Hungarian
( ) Greek ( ) Guarathi ( ) Hebrew ( ) Hindi
( ) Italian ( ) Japanese ( ) Polish ( ) Thai
( ) Korean ( ) Persian ( ) Portuguese ( ) Urdu
( ) Russian ( ) Croatian ( ) Vietnamese

RACE/ETHNICITY:

( ) Hispanic/Latino ( ) Caucasian ( ) Amerasian
( ) American Indian ( ) Chinese ( ) Vietnamese
( ) Alaskan Native ( ) Korean ( ) Cambodian
( ) African American ( ) Guamanian ( ) Korean
( ) Asian Indian ( ) Filipino ( ) Laotian
( ) Hawaiian/Pacific Islander ( ) Samoan ( ) Asian

Parent/Guardian Information

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Relationship to Patient: _____ Social Security Number: _____ - _____ - _____ Male [ ] Female [ ]

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: ( ) _____ Cell: ( ) _____ Other: ( ) _____

Employer _____ Telephone: ( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Information

Dental Insurance Carrier Name: _____ Medical Insurance Carrier: _____

Subscriber Name: _____ Subscriber SSN: _____

Subscriber ID Number: _____ Group Number: _____

Patient Medical History

Have you had any of the following:

___Heart Murmur
___Nervous
___Diabetes
___Cancer
___Blood Disease
___Thyroid Disease
___High Blood Pressure
___Low Blood Pressure
___Radiation Treatment
___ Respiratory Problems
___ Psychiatric Care
___ Arthritis
___ Stroke
___ Epilepsy
___ Ulcers
___ Rheumatic Fever
___ Hemophilia
___ AIDS/HIV
___ Back Problems
___ Circulatory Problems
___ Hepatitis, Liver Disease
___ Allergies to Medicines
___ Artificial Heart Valves
___ Mitral Valve Prolapse

Do you have any drug allergies or adverse reaction to any medication? _____

Are you taking any medications at this time? _____ If so, which medications?_____

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled.

Signature: _____ **Date:** _____

Patient/Parent/Legal Guardian