



S. Mirfendereski, D.D.S.
65 East State St.
Columbus, OH 43215

CHILD INFORMATION:

Child's Name (Last) _____ (First) _____ (Nickname) _____
Child's Date of Birth _____ Father's Name _____ Mother's Name _____
Home Phone No. _____ Father's Work No. _____ Mother's Work No. _____
Street Address _____ City _____ St. _____ Zip _____
Father's Social Security No. _____ Father's Date of Birth _____ Mother's S.S. No. _____ Mother's Date of Birth _____
Father's Employer _____ Mother's Employer _____
Address _____ City, St., Zip _____
Primary Insurance Carrier _____ Secondary Insurance Carrier _____
Address _____ City, St., Zip _____

DENTAL HISTORY Is this your child's first visit to the dentist? Yes No
Has your child been having any specific problems? Yes No Describe: _____
Last dental visit: _____ Purpose: _____ Last complete exam: _____
Has your child experienced any unfavorable reaction from any previous dental or medical care? Yes No Specify: _____
How do you describe your child's dental health? Good Fair Poor
Do you think your child has active dental disease: Decay? Yes No Gum Disease? Yes No
Child's home care: Brush? Yes No Floss? Yes No Other? _____
Does your child's gums ever bleed? Yes No How often? _____ Does your child have bad breath? Yes No
Does your child have any bad mouth habits? Yes No Specify _____

MEDICAL HISTORY (Confidential. Repeated every five years.) BIRTH DATE: (MONTH/DAY/YEAR) _____

Pediatrician/doctor's name: _____ Last physical exam: _____ Current age: _____
Does your child have any medical problems? Yes No Describe: _____
Is your child under a doctor's care now? Yes No If so, for what reason? _____
Is your child taking any medications, pills or drugs? Yes No Please list: _____
Has your child ever had any of the following? Indicate YES with check mark (✓).
 Heart disease. Measles. Tonsillitis. Hepatitis. Epilepsy. Asthma
 Heart murmur. Mumps. Jaundice. Prolonged bleeding. Fainting spells. Allergy to medicine/drugs.
 Rheumatic fever. Scarlet fever. Kidney disease or dialysis. Herpes. Seizures or convulsions. Allergy to anesthetics.
 High blood pressure. Typhoid fever. Tuberculosis. Aids. Psychiatric treatment. Allergy to foods.
 Diabetes. Chicken pox. Arthritis. Malignancies. Prosthetic valves/joints. Other allergies.
List all of your child's allergies here: _____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian Signature/Date: _____ X _____ Reviewed by Doctor/Date: _____ X _____
FOR OFFICE USE ONLY
B/P _____