TED LOIBEN, D.D.S. PEDIATRIC DENTIST, LTD.

Patient/Parent Information

Mother's Name _____ SS# _____ Birthdate _____

Father's Name _____ SS# _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Cell Phone (Mother) _____ Cell Phone (Father) _____

Home Phone _____ E-Mail _____*

Bus. Phone (Mother) _____ Occupation _____

Company Name/Address _____

Bus. Phone (Father) _____ Occupation _____

Company Name/Address _____

Other Parent If At Different Address

Name _____ Home Phone # _____

Address _____E-Mail _____

City _____ State _____ Zip _____

Patient Full Name(s)	**M/F**	**Birthdate**	**Nickname?**
1) _____	/____/	_____	_____
2) _____	/____/	_____	_____
3) _____	/____/	_____	_____
4) _____	/____/	_____	_____

I understand and acknowledge that I am financially responsible for all charges for professional services rendered to the family member(s) listed above. There will be a $35 service fee for all returned checks.

Signature: _____ Date: _____

I will be paying for today's professional services by: **[ ] Cash [ ] Check [ ] Visa [ ] MasterCard [ ] Discover**

TED LOIBEN, D.D.S.
MEDICAL AND DENTAL HEALTH HISTORY

DATE: _____

Patient Name _____ Date of Birth _____Weight _____

Name of Contact (other than parents) for Emergencies _____

Contact's Relationship to Patient _____ Phone # _____

Pediatrician's Name _____

_____ _____
Address (or city) Phone

1. Is your child under a physician's care at this time? _____

   If Yes, why? _____

2. Is your child presently taking any medication? _____

   If Yes, name of medication _____ Dosage _____

3. Has your child had an allergic reaction to any medication or an adverse drug reaction? __

   If Yes, what medication(s)? _____ Describe reaction: _____

   _____

4. Has a physician ever informed you that your child requires antibiotics before dental treatment? _____

5. Has your child ever been hospitalized? _____
   If Yes, describe the circumstances (why, when, where?)

   _____

   _____

6. Please place an "X" to indicate if your child has a history of the following:

___ Anemia	___ Bleeding Problems	___ Cerebral Palsy
___ Arthritis	___ Speech Problems	___ Muscular Dystrophy
___ Asthma	___ Breathing Problems	___ Chicken Pox
___ Autism	___ Circulatory Problems	___ Physical Disabilities
___ Diabetes	___ Hearing Problems	___ Learning Disabilities
___ Epilepsy	___ Heart Problems	___ Mental Retardation
___ Hepatitis	___ Heart Murmur	___ Nutritional Problems
___ HIV Positive	___ Kidney Problems	___ Metabolism Problems
___ Malignancies	___ Liver Problems	___ Rheumatic Fever
___ Measles	___ Intestinal Problems	___ Scarlet Fever
___ Mumps	___ Nervous Problems	___ Tonsillitis
___ Seizures	___ Glandular Problems	___ Psychiatric Problems

CHECK HERE IF YOUR CHILD HAS NO HISTORY OF ANY OF THE ABOVE: ___ NONE

7. Are there any other pertinent facts in your child's history? _____

_____

8. Reason for today's visit _____

9. Is this your child's first visit to the dentist? _____

10. Does your child have any particular fears or apprehensions? _____

_____

11. Has your child ever had a negative dental or medical experience? Describe. _____

_____

12. What could Dr. Loiben do differently than previous doctors to satisfy you? _____

_____

13. How were you referred to Dr. Loiben? _____

I have provided all pertinent facts regarding my child's medical and dental history.

Signature of Parent or Legal Guardian: _____ Date: _____