

GABRIEL MALOUF, DDS

MODERN DENTISTRY • FAMILY VALUES

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Please answer all questions on **both** sides, so that we may diagnose your child's oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

CHILD'S NAME _____ Nickname _____

Male Female Birthdate _____ Age _____

Stepfather Guardian

FATHER'S NAME _____ Birthdate ____/____/____ Social Security No. ____ - ____ - ____

Mailing Address _____ Home Phone (____) ____ - ____

City _____ State _____ Zip Code _____

Father's Occupation _____ Employer _____ Work Phone (____) ____ - ____

Married Single Divorced Separated Widowed

Stepmother Guardian

MOTHER'S NAME _____ Birthdate ____/____/____ Social Security No. ____ - ____ - ____

Mailing Address _____ Home Phone (____) ____ - ____

City _____ State _____ Zip Code _____

Mother's Occupation _____ Employer _____ Work Phone (____) ____ - ____

Married Single Divorced Separated Widowed

With whom does this child reside? _____

PRIMARY DENTAL INSURANCE

SECONDARY DENTAL INSURANCE

Employee _____ Employee _____

Relationship to Patient _____ Relationship to Patient _____

Employer _____ Employer _____

Insurance Co. _____ Group # _____ Insurance Co. _____ Group # _____

Insured Birthdate ____/____/____ Insured Birthdate ____/____/____

Employee's S.S. No. ____ - ____ - ____ Employee's S.S. No. ____ - ____ - ____

Person responsible for child's account: _____ Phone No. (____) ____ - ____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

Relationship to Patient _____ Closest Relative _____ Phone No. (____) ____ - ____

How did you hear about our office?

Location Postcard Referral Card Office Website Hometown Values

Phonebook Sno Valley Star Insurance Internet Other _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Is this your child's first dental visit? Yes No
 Previous Dentist's Name? _____
 Date of last visit: _____
 Does your child feel nervous about having dental treatment? Yes No
 Has your child ever had a bad dental experience? Yes No
 Has your child been seen by an orthodontist? Yes No

Have there been any injuries to your child's teeth or jaws? Falls? Blows? Chips? etc? Yes No
 Has your child ever been premedicated for dental work? Yes No
 Does your child receive fluoride in vitamins, tablets, or water? Yes No

HEALTH HISTORY

Is your child having any pain or discomfort at this time? Yes No
 Has your child been hospitalized during the past 2 years? Yes No
 Has your child been under the care of a medical doctor during the past 2 years? Yes No
 Is your child currently taking any medications? Yes No
 If yes, please list: _____

Has your child taken any medicine / drugs during the past 2 years? Yes No
 If yes, please list: _____
 Please list any serious medical condition(s) that your child has or has had: _____

Please check "Yes or No" to the following conditions:

- | | | | |
|--|--|---|--|
| <p>Y N
 <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris
 <input type="checkbox"/> <input type="checkbox"/> Heart Disease / Attack / Stroke
 <input type="checkbox"/> <input type="checkbox"/> Heart Failure
 <input type="checkbox"/> <input type="checkbox"/> High / Low Blood Pressure
 <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect
 <input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Rheumatic Fever
 <input type="checkbox"/> <input type="checkbox"/> Heart Surgery
 <input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker
 <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve
 <input type="checkbox"/> <input type="checkbox"/> Diabetes</p> | <p>Y N
 <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease
 <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion / Anemia
 <input type="checkbox"/> <input type="checkbox"/> Bruise Easily
 <input type="checkbox"/> <input type="checkbox"/> Hemophilia
 <input type="checkbox"/> <input type="checkbox"/> Liver Disease / Yellow Jaundice
 <input type="checkbox"/> <input type="checkbox"/> Kidney Failure/Dysfunction
 <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
 <input type="checkbox"/> <input type="checkbox"/> Glaucoma
 <input type="checkbox"/> <input type="checkbox"/> Chemotherapy / Cancer
 <input type="checkbox"/> <input type="checkbox"/> X-ray / Cobalt Treatment</p> | <p>Y N
 <input type="checkbox"/> <input type="checkbox"/> Ulcers
 <input type="checkbox"/> <input type="checkbox"/> Emphysema / Asthma
 <input type="checkbox"/> <input type="checkbox"/> Cough / Tuberculosis (TB)
 <input type="checkbox"/> <input type="checkbox"/> Arthritis / Rheumatism
 <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine
 <input type="checkbox"/> <input type="checkbox"/> Venereal Disease
 <input type="checkbox"/> <input type="checkbox"/> A.I.D.S. / H.I.V.
 <input type="checkbox"/> <input type="checkbox"/> Hepatitis: A B C (circle one)
 <input type="checkbox"/> <input type="checkbox"/> Pain in Jaw Joint
 <input type="checkbox"/> <input type="checkbox"/> Artificial Joints (Hip, Knee)</p> | <p>Y N
 <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches
 <input type="checkbox"/> <input type="checkbox"/> Fever Blisters / Cold Sores
 <input type="checkbox"/> <input type="checkbox"/> Fainting / Dizzy Spells
 <input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures
 <input type="checkbox"/> <input type="checkbox"/> Hay Fever / Sinus Trouble
 <input type="checkbox"/> <input type="checkbox"/> Allergies / Hives
 <input type="checkbox"/> <input type="checkbox"/> Shingles
 <input type="checkbox"/> <input type="checkbox"/> Nervousness
 <input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
 <input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol Addiction</p> |
|--|--|---|--|

Is your child allergic to or reacted adversely to any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Metals / Jewelry | <input type="checkbox"/> Local/Dental Anesthetic |

Does your child have allergies to any other medications or substances? If yes, please list:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 authorize Dr. Gabriel Malouf and/or dental staff to perform the necessary dental services my child my need.

Parent/Guardian Signature _____ Date ____ / ____ / ____

Medical History Update

(For Office Use Only)

Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____
Date _____ Comments _____	Date _____ Comments _____
Parent's Signature _____	Parent's Signature _____