Brian T. Brumbaugh, D.D.S.
"Ride the Cavity Free Express"

Date_____

Patient Name_____ Middle Initial____ Preferred Name_____

Birth Date_____ Age_____ Sex M F E-Mail Address_____

Mailing Address_____

Physical Address_____

Child is: Biological Adopted In foster Care

Mother:_____ Home:_____ ____ Cell:_____

Mothers Employer_____ Work #_____ OK to call at Work: Y N

Father:_____ Home:_____ Cell:_____

Father's Employer_____ Work #_____ OK to call at work: Y N

Marital status of Parent(s): □ Married □ Single □ Separated □ Divorced

Custody Situation: Sole Custody Joint Custody **If someone does not have legal rights to patient named above, a copy of the custody order must be obtained for verification. Otherwise, single or divorced parents are assumed to have joint custody.

Name of Responsible Party: _____ Relationship to Patient: _____

SSN_____ Birth Date_____ Phone Number_____

Medical History

General Health Review: Please review your child's past and present medical history. Mark *only* if your child has the condition now, or has been treated for it in the past.

Allergy: □ Latex □ Drug □ Food □ Other Explain: _____

□ ADHD	□ Cleft lip/Palate	□ Seasonal Allergies
□ Anemia	□ Cold Sores	□ Heart Murmur
□ Asthma	□ Diabetes	□ Hepatitis
□ Autism	□ Downs Syndrome	□ Kidney Disease
□ Asperger Syndrome	□ Epilepsy	□ Liver Disease
□ Blood Disorder	□ Hearing problems/Deaf	□ Respiratory Problems
□ Cancer	□ Heart Disease	□ Recurring Headaches
□ Cerebral Palsy	□ HIV/AIDS	□ Vision Impaired/Blind
□ Social Disorder	□ Mental Delays	□ Physical Delays

Is Pre-medication required before dental appointments? Y N

_____

Has child ever been hospitalized? Y N

_____

Is your child taking any medication? Y N _____