Anesthesia for Dentistry
Raj Misra, D.D.S., P.C.

Fax: 817-488-9685
Phone: 817-909-1023
DFWA4D@gmail.com
www.DFWA4D.com

Child Health History

PATIENT INFORMATION (CONFIDENTIAL)

Today's Date_____

Name:_____ Date of Birth: _____ Age:_____

Nickname:_____Sex:_____ Height:_____Weight_____

Address: _____City: _____State: _____ Zip:_____

Home Phone:_____Social Security #: _____

RESPONSIBLE PARTY

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Driver's License #:_____Birth Date:_____

Home Phone: _____ Cell Phone/Pager:_____Fax:_____

Email: _____Social Security#_____

Address: _____City: _____State: _____Zip:_____

Employer: _____Work Phone #:_____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y	N	Allergies to any drugs	Y	N	Diabetes	Y	N	Phen-Fen Use present/past
Y	N	Any Hospital Stays	Y	N	Seizures / Epilepsy	Y	N	Tuberculosis
Y	N	Any Operations	Y	N	Handicaps / Disabilities	Y	N	Heart Murmurs
Y	N	Latex Allergy	Y	N	Cancer	Y	N	Kidney Problems
Y	N	Bleeding Problems	Y	N	Rheumatic / Scarlet Fever	Y	N	Developmentally Delayed
Y	N	Hearing Impairments	Y	N	Heart Defects	Y	N	Cerebral Palsy
Y	N	Asthma / Lung Problems	Y	N	Hepatitis / Liver problems			

Weight_____ Height_____

Please discuss any medical problems that the child has/had: _____

_____

_____

Child's Physician: _____Phone Number:_____

Is your child currently under the care of a physician: Yes__No__ Date of Last Visit: _____

Please describe child's current physical health: Excellent _____Good_____Poor_____

Please list all medications the child is currently taking:_____

_____

Please list all allergies the child has including medications:_____

_____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Misra of any changes in my medical status at the earliest possible time.

Signature of Patient_____ Date _____

Reviewed by: _____ Date _____