**KIMBERTON DENTAL ASSOCIATES – Pediatric Patient Questionaire**

*Dr. Nhat-Khai Do – Dr. Darry Ma*

## I. Patient Information:

Patient Name: ______________________________ SS#: _______________ DOB: ______________

Preferred name: ___________________________ Favorite pet(s): ______________________________

**II. Parents/ Legal guardian/ Person responsible for child's account**:

Mr. / Mrs. _________________________________ SS#: _______________ DOB: ______________

Male ☐ Female ☐ Other ☐ Single ☐ Married ☐ Divorced ☐

Address: ______________________________________________________________________________

______________________________________________________________________________

Contact phone number: ______________________ Alternative contact number: ___________________

Name of the insurance company for the child: ___________________________________________________

Signature: ________________________________________ Today's date: ______________________

## II. Medical History:

| | Yes | No |
|---|---|---|
| 1. Is the patient in good health? __________________________________________ | ☐ | ☐ |
| 2. Is the patient sensitive or allergic to anything? ___________________________ | ☐ | ☐ |
| 3. Has the patient experienced any unfavorable reaction from any previous dental or medical care? _____________________________________ | ☐ | ☐ |
| 4. History of heart trouble, rheumatic fever, epilepsy, diabetes, bleeding, or mental disorders? (please circle) ______________________________ | ☐ | ☐ |

Please use reverse side for any additional information regarding patient's history.


**KIMBERTON DENTAL ASSOCIATES – Pediatric Patient Questionaire**

*Dr. Nhat-Khai Do – Dr. Darry Ma*

## I. Patient Information:

Patient Name: ______________________________ SS#: _______________ DOB: ______________

Preferred name: ___________________________ Favorite pet(s): __________________________

**II. Parents/ Legal guardian/ Person responsible for child's account**:

Mr. / Mrs. _________________________________ SS#: _______________ DOB: ______________

Male ☐ Female ☐ Other ☐ Single ☐ Married ☐ Divorced ☐

Address: ______________________________________________________________________________

______________________________________________________________________________

Contact phone number: ______________________ Alternative contact number: ___________________

Name of the insurance company for the child: ___________________________________________________

Signature: ________________________________________ Today's date: ______________________

## II. Medical History:

| | Yes | No |
|---|---|---|
| 1. Is the patient in good health? __________________________________________ | ☐ | ☐ |
| 2. Is the patient sensitive or allergic to anything? ___________________________ | ☐ | ☐ |
| 3. Has the patient experienced any unfavorable reaction from any previous dental or medical care? _____________________________________ | ☐ | ☐ |
| 4. History of heart trouble, rheumatic fever, epilepsy, diabetes, bleeding, or mental disorders? (please circle) ______________________________ | ☐ | ☐ |

Please use reverse side for any additional information regarding patient's history.