

KIMBERTON DENTAL ASSOCIATES – Pediatric Patient Questionnaire

Dr. Nhat-Khai Do – Dr. Pei Ting Sawyer

I. Patient Information:

Patient Name: _____ SS#: _____ DOB: _____
Male ☐ Female ☐ Other ☐
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.

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