Walla Walla Pediatric Dentistry
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PATIENT'S CONFIDENTIAL INFORMATION.

Patient Information *(Información del Paciente)*

Name:____ **Sex:** ☐ M ☐ F
(Nombre) *Last Name (Apellido)* *First Name (Nombre)* *Middle (Inicial)* *(Sexo)*

Date of Birth: ________________ **Contact Information: Preferred Phone #**________________ **Text:** ☐ Yes ☐ No
(Fecha de Nacimiento) *(Información de contacto) (Teléfono de preferencia)* *(Texto) Si No*

Alternate Phone #____________________ **Email**:________________________________
(Teléfono alternativo) *(Correo Electronico)*

Address:________________________________ **City:**____________ **State:**______ **Zip:**________
(Dirección) *(Cuidad)* *(Estado)* *(Zona Postal)*

Whom may we thank for referring you? ____
(¿Quién lo refirió a nuestra oficina?)

Parent/Guardian Information *(Información de los Padres/Guardianes)*

Father/Guardian Name:____________________________
(Nombre del Padre/Guardián)
Address: Same as patient? ☐ Yes ☐ No
(Dirección): Igual al paciente? Si No
If not, please list: ____________________________
Si no, por favor escriba
City:________________ **State:**______ **Zip:**________
(Cuidad) *(Estado)* *(Zona Postal)*
Home:__________ **Work:**__________ **Cell:**__________
(Tel Casa) *(Tel. Trabajo)* *(Tel. Celular)*
Occupation:____________________________
(Ocupación)
Employer:____________________________
(Empleador)
Date of Birth:____________
(Fecha de Nacimiento)

Mother/Guardian Name:____________________________
(Nombre de la Madre/Guardián)
Address: Same as patient? ☐ Yes ☐ No
(Dirección): Igual al paciente? Si No
If not, please list: ____________________________
Si no, por favor escriba
City:________________ **State:**______ **Zip:**________
(Cuidad) *(Estado)* *(Zona Postal)*
Home:__________ **Work:**__________ **Cell:**__________
(Tel Casa) *(Tel. Trabajo)* *(Tel. Celular)*
Occupation:____________________________
(Ocupación)
Employer:____________________________
(Empleador)
Date of Birth:____________
(Fecha de Nacimiento)

In the event of an emergency, whom should we contact? Someone other than Parent/Guardian (contacto de emergencia)?

Name:________________________ **Relationship:** ________________ **Phone:**____________
(Nombre) *(Relación con el Paciente)* *(Número de Teléfono)*

Medical Information

Child's physician:____________________________ Date of last physical exam: ______________

Does your child have a history of:

Surgeries? ☐ Yes ☐ No List type: ________________________________
Current medications? ☐ Yes ☐ No List type and dosages:____________________________
Allergic to any medications/ latex/foods? ☐ Yes ☐ No List:____________________________
Immunizations up to date? ☐ Yes ☐ No

Please check if your child has a history of any of the following:

☐ Heart disease or murmur
☐ Asthma
☐ Blood disorder
☐ Blood transfusion
☐ Diabetes
☐ Liver disease
☐ Kidney disease
☐ Epilepsy, seizures, fainting
☐ Developmental delay
☐ Behavioral/emotional problems
☐ Arthritis
☐ Motor or muscle disorder
☐ Cancer or tumors
☐ HIV/AIDS
☐ Tuberculosis (TB)
☐ Gastrointestinal issues
☐ Thyroid disease
☐ Hearing or vision problems
☐ Speech delay
☐ Tobacco use
☐ Chemical dependency
☐ Premature birth (Weeks? ________)

Females only: Is there any possibility of pregnancy? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Is your child adopted? ☐ Yes ☐ No **Does he/she know?** ☐ Yes ☐ No
Does your child have any other medical issues or special needs? ☐ Yes ☐ No Please list:
____

Signature of Parent/Guardian: ________________________________ **Date:** ____________