



NEW PATIENT INFORMATION FORM

Childs Name _____
Last First Middle

Childs Address _____

Nickname _____

Home Phone # _____

Childs Cell # _____

Circle One : Male Female

Date of Birth _____

Referred by: _____ School _____

Pediatrician Name: _____

Pediatrician Phone # _____

Has your child ever had any of the following medical problems? Please circle if yes:

- | | | |
|-------------------|---------------|-------------------------|
| Abnormal Bleeding | Anemia | Cancer |
| Chicken Pox | Convulsions | Epilepsy |
| Asthma | Diabetes | Hemophilia |
| Hepatitis | Hives | Kidney/Liver Problems |
| Measles | Mononucleosis | Rheumatic/Scarlet Fever |
| Skin Rash | Tuberculosis | HIV/AIDS- negative |

Does your child have a congenital heart defect? Yes No

Does your child have any history of heart murmurs? Yes No

If yes, please list type _____

Has your child been diagnosed with Autism/Special Needs? Yes No

If yes, please explain _____

Is your child allergic to any medications? Yes No

If yes, please list _____

Why did you bring your child to the dentist today? _____

Please indicate if you have other children that have been a patient of Dr. Santiago:

Does/did your child have any of the following habits?

- Lip Sucking/ Biting
- Nail Biting

Please circle if yes:

- Nursing/ Bottle Habits
- Thumb/Finger Sucking

Was the child ever breast fed? Yes No

Is the child adopted? Yes No