# Alana K. Macalik

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## Tell Us About Your Child

Today's Date:_________________

Child's Name:_______________________

Nickname: ____________ ☐ Male ☐ Female

Child's DOB:___/___/______ Age: ____

Home Address:_______________________

_________________________________
CITY STATE ZIP

### Best Way To Be Contacted:

Cell #:(___)_________Hm #:(___)_________

SS #:___________ DL #:____________

School: ___________________________

### Who Is Accompanying The Child Today?

Name:_______________ Relation:______

Do you have legal custody of this child?

☐ Yes ☐ No

**In the event of an emergency, who should we contact?**

Name:_____________________________

Relationship:________________________

Cell/Home: (____)____________________

Work: (____)________________________

## Dental Insurance

Insurance Co. Name, Address and Phone #:

_________________________________

_________________________________

Group, Plan, Local or Policy #:____________

Insured's Name:______________________

Relationship to Patient:_________________

Insured's DOB:___/___/____

Insured's ID#:______________________

Insured's Employer and Address:

__________________________

### How did you hear about our office?

_________________________________

### Other family members seen by us:

_________________________________

### Who is responsible for making appointments?

_________________________________

## Person Responsible For Account

Name:____________________________

Relation:__________________________

Billing Address: ______________________

_________________________________

ALANA K. MACALIK

# Parent Information

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

**☐ Mother ☐ Step-Mother ☐ Guardian**

Name:_________________________ DOB:__________

Cell #:(___)__________Wk #:(___)___________

Employer:________________________________

Email:________________________________________

SS #:_________________________

**☐ Father ☐ Step-Father ☐ Guardian**

Name:_________________________ DOB:__________

Cell #:(___)__________Wk #:(___)___________

Employer:________________________________

Email:________________________________________

SS #:_________________________

**Please list all prescription, over-the-counter medications or supplements your child takes:**

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

**Drug Allergies**

____ Aspirin

____ Erythromycin

____ Codeine

____ Jewelry or Metals

____ Dental Anesthetic

____ Acrylic

____ Latex

____ Penicillin

____Sulfa Drugs

____ Tetracycline

Other:______________________________

Alana K. Macalik

# Medical History

**CHECK ALL THAT APPLY**

____ AIDS/HIV Positive
____ Abnormal Bleeding / Hemophilia
____ Anemia
____ Asthma or Hay Fever
____ Auto-Immune Disease
____ Blood Transfusion
____ Cancer: Type/Dates________________
____ Chronic Cough
____ Cold sores/Fever blisters/Mouth ulcers
____ Congenital heart defect
____ Crohns Disease
____ Diabetes: Date Diagnosed: __________
Type____________
____ Difficulty Breathing
____ Eating Disorders
____ Epilepsy / Seizures / Fainting Spells
____ Excessive Thirst
____ Heart Murmur
____ Hospitalized for Any Reason
Specify:_________________________
____ Hypoglycemia
____ Immune Suppressed
____ Irregular Heartbeat
____ Mitral Valve Prolapse
____ Psychological Problems
____ Rheumatic fever / Scarlet fever
____ Severe / Frequent Headaches
____ Sickle Cell Disease / Traits
____ Seasonal Allergies
____ Sinus Problems
____ Stomach Ulcers / Colitis
____ Surgery in the last 12 months
____ Tuberculosis (TB)

**Currently under the care of a physician?**

Please Explain:_________________________

**Pharmacy**:_______________ (__)__________

**Please list any other serious medical condition(s) that your child has ever had:**

__________________________________________
__________________________________________
__________________________________________
__________________________________________

The information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment with my informed consent.

______________________________________________________________

Signature (Parent/Guardian) Date