MARK PIMPER, D.D.S., P.C.
2929 West 17th Avenue
Longmont, CO 80503

PATIENT MEDICAL HISTORY

Child's Name________________________________Date of birth____________

Street address____________________________City__________State________

Zip ________Home Phone ______________

Nickname__________________Age______Grade_____School__________________

Child's Interests____

Father's Name_______________________Home Phone____________________

Mother's Name_______________________Home Phone____________________

Date of last dental examination____________Medical examination________________

Has Child ever been hospitalized?_________If so, for what?____________________

Has Child ever had:

	Yes	No		Yes	No
Aids	___	___	Rheumatic Fever	___	___
Anemia	___	___	Heart murmur	___	___
Diabetes	___	___	Chicken Pox	___	___
Epilepsy	___	___	Mumps	___	___
Hepatitis	___	___	Measles	___	___
Abnormal blood pressure	___	___	Abnormal Heart Condition	___	___
Abnormal bleeding from a cut	___	___			

If Allergies to medications or drugs, indicate which ones______________________

Medications child is taking____

If so, for what?____

Other physical conditions____

Is child receiving other health care now?_________If so, nature of care___________

Name of physician________________________________Phone______________

Address____

May we request your child's health records if necessary______________

To whom should we address request?___________________________

Signed____________________________________Date__________

(Guardian, if child)