Steven S. Sabatino DDS, MS, PLLC
Child History Form
Patient Information

Date:_____

Child Name:_____

Name Child prefers to be called:_____
Male:_____ Female:_____ Height:_____ Weight:_____ Date of Birth:_____ Age:_____
Child's Home Address:_____
City:_____ State:_____ Zip:_____
Child's Home Phone#: _____ Cell #:_____
School Child is attending:_____ Grade:_____
Special Interests Sports/Hobbies:_____ Musical Instrument:_____
Who may we thank for referring you to our Office?_____
Who is accompanying this child today?_____
Your relationship to Child:_____ Are you the responsible Party?_____
(Natural Parent?) __Yes __No) (Child Adopted? __Yes __No) (Foster Parent? __Yes __No)
(Other – specify relationship_____)
Names & Ages of other Family Members:_____
_____
Are any family members patients of Dr. Sabatino?_____
Emergency Contact (Nearest relative not living with you.) Name:_____
Relationship:_____ Work #:_____ Home #:_____

Mother_____ **Father**_____
Marital Status __Married __Divorced __Widow __Single __Remarried
__ Mother __ Father __ Stepparent __ Guardian Date of Birth_____
Social Security Number_____ Email_____
Name_____
Work or Cell_____ Occupation_____
Address_____
City_____State_____Zip_____Home Phone_____
Employer_____Employer Address:_____

Mother_____ **Father**_____
Marital Status __Married __Divorced __Widow __Single __Remarried
__ Mother __ Father __ Stepparent __ Guardian Date of Birth_____
Social Security Number_____ Email_____
Name_____
Work or Cell_____ Occupation_____
Address_____
City_____State_____Zip_____Home Phone_____
Employer_____Employer Address:_____

Orthodontic Insurance Information

Primary Insurance Information Relationship to Patient_____
Insured's Name_____ Insured's Date of Birth_____
Insured's Social Security #_____ Employer's Name_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone #_____ **Name of Dental Plan**_____

(We will need a copy of your "Dental Plan Insurance Card")

Secondary Insurance Information Relationship to Patient_____
Insured's Name_____ Insured's Date of Birth_____
Insured's Social Security #_____Employer's Name_____
Employer's Address_____ City_____ State_____ Zip_____
Insurance Company_____ City_____ State_____ Zip_____
Insurance Phone #_____ **Name of Dental Plan**_____