



**Dr. Roslyn M. Crisp**

1203 Vaughn Road  
Burlington, NC 27215  
228-8392

**MEDICAL HISTORY**

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Father Employed By: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Full Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mother Employed By: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status of Parents: Married / Separated / Divorced / Other \_\_\_\_\_

Name and number of nearest relative not living with you: \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

Do you have Dental Insurance? \_\_\_\_\_ Medicaid? \_\_\_\_\_

**PAYMENT OF PROFESSIONAL FEES:** The policy of payment for dental services in this office will be cash, check, Visa and Mastercard. Payment is expected the day that services are rendered. Portions of the bill not covered by insurance or medicaid are the responsibility of the parent or guardian and is due in full at the conclusion of each dental visit. Medicaid recipients must present a current medicaid card on the day of the visit. I understand and agree to these terms.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Has your child ever had or been treated by a physician for:

	CHECK		
	Yes	No	?
Hearing problems			
Eye problems			
Skin problems			
Tonsil/adenoid problems			
Sleep problems			
Emotional/behavior problems			
Attention deficit disorder			
Hepatitis			
AIDS or HIV+			
Tuberculosis			
Liver disease			
Kidney disease			
Diabetes			
Asthma			
Speech problems			

	CHECK		
	Yes	No	?
Problems at birth			
Heart murmur			
Heart disease			
Rheumatic fever			
Anemia			
Sickle Cell Anemia			
Bleeding/Hemophilia			
Blood transfusion			
Arthritis			
Cancer			
Cerebral Palsy			
Seizures			
Autism			
Cleft lip/Palate			

If yes to any above, please explain: \_\_\_\_\_

Is your child taking any medications at this time? \_\_\_\_\_

Name of patient's physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Allergies (Please List): \_\_\_\_\_

Do you consider your child to be (Check One):  
Advanced in learning \_\_\_\_\_ Progressing normally \_\_\_\_\_ Slow learner \_\_\_\_\_

