Welcome to Dr. Sherick's Office

Print clearly and complete both sides. A signature is required.

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Patient's Name: Date of Birth:/ /	A N		
Patient's school:		tient interests:	
Child's home address:			
Child's home phone number :()	Primary Fam	illy Email:	
Who is accompanying your child today? Nat	ne:	Relation:	
Does this person have legal custody of this c			
Whom may we thank for referring you?			
Other family members seen by us:			
Parent's marital status: Single Married			
Mother's Information:			
	Data of Dirth.		Nather /Cteresether
Name:			Mother/Stephother
Home Address:			
How long at this address:			
Previous address (if less than three years):			
Employer:	Occupation:	Years	of Employment:
Home Phone: ()	Work Phone: () Cell Ph	one :()
Social Security Number:	Drive	r's License Number:	
Father's Information:			
Name:	Date of Birth:	/ /	Father/Stepfather
Home Address:			
How long at this address:			
Previous address (if less than three years):			
Employer:	Occupation:	Vears	of Employment:
Home Phone: ()	Occupation		one:()
Social Security Number:			
	DIIVC		
Person(s) Financially Responsible for the Acc	count:		
Person(s) Financially Responsible for the Acc Name(s):			
Name(s):		Relation:	
Name(s): Billing Address:		Relation:	
Name(s): Billing Address: Previous Address:		Relation:	
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			-	HISTORY				
Name of Physician						s:		_
las your child eve	r been diagn	osed with a	any of the following dise		dical condi	tions?		
Abnormal or Exces	sive		Delayed developmen	t Y	Ν	Nervous disorder	Y	Ν
Bleeding	Y	Ν	Diabetes	Y	Ν	Pacemaker	Y	Ν
ADD/ADHD	Y	Ν	Endocrine problems	Y	Ν	Pregnancy	Y	Ν
Allergies to Drugs	Y	Ν	Emotional problems	Y	Ν	Currently pregnant	Y	Ν
Allergies to Latex o	or		Fainting or dizziness	Y	Ν	Psychiatric treatment	Y	Ν
Metals	Y	Ν	Glaucoma	Y	Ν	Rheumatic/Scarlet		
Allergies to Plastic	s Y	Ν	Handicaps or disabilit	ties Y	Ν	fever	Y	Ν
Any hospital stays	Y	Ν	Headaches (recurren	t) Y	Ν	Sinus trouble	Y	Ν
Any surgeries	Y	Ν	Hearing impairment	Y	Ν	Stomach ulcers	Y	Ν
Artificial bones, joi	ints, or		Heart disease	Y	Ν	Stroke	Y	Ν
valves	Y	Ν	Heart murmur	Y	Ν	Tonsillitis (recurrent)	Y	Ν
Asthma	Y	Ν	Hepatitis (A/B/C)	Y	Ν	Tuberculosis	Y	Ν
Bone disorders	Y	Ν	(please circle one)					
Cancer or maligna	ncies Y	Ν	High blood pressure	Y	Ν			
Congenital heart d		Ν	HIV/AIDS	Y	Ν	Other		
Convulsions, epile			Kidney/liver problem		Ν			-
or seizures	Ŷ	Ν						
				Fair		Poor		
ist any medicatio	n your child i	is currently	taking:					
List all drug allergie	es or sensitiv	/ities (not p	reviously mentioned):					
las your child eve	r taken any o	of the follow		i-Phen	Redux	Pondimin		_
			Zometa Are	i-Phen dia	Redux Boniva	Actonel	Fosama	ix
			Zometa Are	i-Phen dia	Redux Boniva	Actonel	Fosama	іх
			Zometa Are	i-Phen dia	Redux Boniva	Actonel	Fosama	іх
f so, when? Does the patient s	moke?		Zometa Are Any additional not pr DENTAL	I-Phen dia eviously me HISTORY	Redux Boniva Dosage: entioned:	Actonel		_
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