Safety on wheels L.L.C.

Phone:(570)-534-9996
Fax:570-471-4480
www.info@safetyonwheels.net

Welcome,

We appreciate the confidence you place with us to provide a transportation services for you and your children.This information is important if there is a TRUE emergency and medical and dental history is needed . To assist us in serving you, Please complete the following form so we are able to assist the child or children if necessary. The information provided on this form is important to your medical and dental health. If there have been any changes in your health, please tell us.

After-school,Facilities and organizations please have parents fill out the necessary information.

If you have any questions, don't hesitate to call or email.
Phone# 570)534-9996 or email:info@safetyonwheels.net

Transporter name: _____
Date of birth: _____ Sex: _____ Age: _____
Home address: _____
City: _____ State: _____ Zip: _____
Billing address (if different): _____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell: _____
E-mail:_____
Driver's license #: _____ State: _____
Employer/Occupation: _____
Bus. Phone: _____
Spouse's name & phone #: _____
Emergency phone # (other than spouse): _____
Primary dental insurance: _____
Group #: _____
Secondary dental insurance: _____
Group #: _____
Subscriber's name: _____
Date of birth: _____ SS #: _____
Name of your medical doctor: _____
Date of last visit to medical doctor: _____
Name of previous dentist: _____
Date of last visit to dentist: _____
Referred to us by: _____
_____

Name of your Dentist:_____
Address:_____
Phone:_____
Email:_____

Name of your Physician:_____
Phone#_____Address_____
Do you have any disease, condition, or problem not listed above?_____
Please add anything else you would like us to know about:_____
_____
_

Medical History
Do you have or have you had any of the following?
(Please check any that apply)
Cancer or tumor_____
Heart ailment or angina_____
Heart murmur, mitral valve prolapse, heart defect_____
Rheumatic fever or rheumatic heart disease_____
Artificial joint or valve_____
High or low blood pressure_____
Tuberculosis or other lung problems_____
Kidney disease_____
Hepatitis or other liver disease_____
Neurologic condition_____
Epilepsy, seizures, or fainting spells_____
Emotional condition_____
Arthritis_____
Herpes or cold sores_____
AIDS or HIV positive_____
Migraine headaches or frequent headaches_____
Anemia or blood disorders_____
Abnormal bleeding after extractions, surgery, or trauma_____
Hay Fever or sinus trouble_____
Allergies or hives_____
Asthma_____
Are you allergic to, or have you reacted adversely to any of the following?
Latex materials_____
Penicillin or other antibiotics_____
Local anesthetics ("Novocain")_____
Codeine or other narcotics_____
Sulfa drugs_____
Barbiturates, sedatives, or sleeping pills_____
Aspirin_____
Other:_____
Are you taking any of the following?
Aspirin_____
Anticoagulants (blood thinners)_____
Antibiotics or sulfa drugs_____
High blood pressure medicine_____
Other:_____

Signature of patient (or parent)_____ Date:_____

Special remarks: