

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. The more we know about your child, the better we can care for them.

6.	
ABOUT YOUR CHILD	INSURANCE INFORMATION
Today's Date:	PRIMARY
	Dental Coverage: Yes: No:
Name:	Insured's Name:
Last First MI	Insured's Birth Date:/
Preferred Name: M F	Relation To Patient:
Birthdate:/ Age:	Insurance Co. Name:
Home Address:	Insurance Co. Address:
	Insurance Co. Ph#; ()
City State Zip	Group#:
Lives with: Mom & Dad:Other:	Insured's ID# or Social Security#:
Whom may we thank for referring you?	Insured's Employer:
Other family members seen by us:	Do you have a secondary Dental Insurance? Y N
Previous/Present Dentist:	DINOIGIAN INFORMATION
Last Visit Date:	PHYSICIAN INFORMATION
DADENT (OLIADDIAN INFORMATION	Physician's Name:
PARENT/GUARDIAN INFORMATION	Phone #:()
Father/Guardian Name:	Are they currently under the care of a physician? YesNo
0	Please Explain:
Last First	
Mother/Guardian Name:	
Last First	DEAD AND GION
Address If Different From Above:	READ AND SIGN
011	I understand that as a courtesy the dental office will submit
Other Other 7th	claims to my insurance for payment of services rendered. I also
City State Zip	understand that I am responsible for payment of services rendered
Cell #: ()	and also responsible for paying any co-payment and deductibles
	that my insurance does not cover. I am aware that payment is
In the event of an emergency, is there someone who lives near	due in full at the time of treatment unless prior arrangements have
you that we should contact?	been approved.
Name:	
Relation:	
Phone #:	Signature Date
A A	

N	ur child allergic to any of the Aspirin Y N Cod Dental Anethetics Y N Eryt	leine	any prescriptions/over-the-counter drugs your child is taking:
N	Jewelry Y N Late Metals Y N Pen Tetracycline Y N Oth	icillin Why	Why have you brought your child to the dentist today?
	ou child had any of the follocal conditions?	wing diseases or —	
	Abnormal Bleeding	Y N Hemophilia	How often does your child brush? Floss?
N N N N N	Cancer/Chemo Chicken Pox Congenital Heart Defect Cold Sores Diabetes Difficulty Breathing Epilepsy Fainting Spells Frequent Headaches	Y N HIV/AIDS Y N Ever Hospitalized Y N Kidney Problems Y N Liver Disease Y N Mitral Valve Prolaspse Y N Radiation Treatment Y N Rheumatic/Scarlet Feve Y N Seizures Y N Shingles Y N Sickle Cell Disase Y N Sinus Problems Y N Spina Bifida Y N Thyroid Problems	Does your child have jaw discomfort? Has your child ever experienced a mouth or chin injury? Y N Does your child have speech problems? Y N Child's habits affecting the mouth or teeth: (circle) Thumb sucking Nail biting Other:
N	Heart Mumur	Y N Tonsillitis	
unde is in y ch	formation will be held in the	strictest confidence and it rize the dental staff to perfo	rrect to the best of my knowledge. I also understand that is my responsibility to inform this office of any changes in orm any necessary dental services that my child may need

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