Child's Name: _____ Date:_____
Last, First MI (Preferred Name)

Gender: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Social Security # *(for insurance purposes)*: _____

Phone *(Home)*: _____ *(Cell)*: _____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency, contact: _____ Phone: _____

Health Information

Has the child ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
  _____
  _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve*****
- ☐ Artificial Joints*****
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis: A, B, or C
- ☐ High Blood Pressure
- ☐ HIV +
- ☐ Kidney Disease
- ☐ Liver Disease, Jaundice
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant** *(NOW)*
  Due date:_____
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

***Any condition marked with an asterisk requires pre-medication be taken prior dental procedures**.*

- List any drug allergies or adverse reactions to medications_____
- List medications the child is taking_____
- Has the child ever had any complications following dental treatment? ☐Yes ☐No
  If yes, please explain:_____
- Has the child been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
  If yes, please explain:_____
- Is the child now under the care of a physician? ☐Yes ☐No
  Name:_____ Phone: _____
- (Women) Is the child taking the birth control pill? ☐ Yes ☐ No
- Does the child have any health problems that need further clarification? ☐Yes ☐No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever have any change in the child's health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Parent Information:

	Father	Mother
Name:		
Street Address:		
City, State and Zip Code:		
Home Phone:		
Cell Phone:		
Birth Date:		
Social Security #:		
Employer:		
Employer City & State:		
Work Phone:		

Does the child have Dental Insurance? ☐ No ☐ Yes:

Primary Insurance Company: _____

Name of Insured: _____ Insured's Date of Birth: _____/_____/_____

ID #: _____ Group #: _____

Secondary Insurance Company: _____

Name of Insured: _____ Insured's Date of Birth: _____/_____/_____

ID #: _____ Group #: _____

Who is responsible for this account? _____ **Relationship to patient**:_____

Consent for Services

The above information is accurate and complete to the best of my knowledge. I authorize my insurance company to pay directly to the dentist. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submission. I will not hold the dentist/staff responsible for any omissions on the form. I understand that the fee estimate listed for any dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Signature Date