

Today's Date:

Child's Name: _____

Insured's Employer:_





About Your Child

File #:_



	LAST FIRST M.I.	-			
5 77	Child's Nickname: Boy _ Gi	rl			
	Child's Birthdate: / / Age:				
	School: Grade:				
	Child's Home Phone #:()	_			
	Child's SS#:				
	Child's Address:	_			
Ϊ	HOME ADDRESS				
J	CITY STATE ZIP	-			
	Referred By:	_			
	(" doord, product give dudiess a priorie nulliber.)				
	Insurance Information	1			
	Primary Dental Insurance				
	Co. Name:				
	Address:				
1	CITY STATE ZIP				
	Phone #:				
V4.0	Insured's ID#:				
	Group # (Plan, Local, or Policy #): Insured's Name:				
	Relation: Date of Birth://	-1			
2	Insured's Employer:				
	Does either policy cover Orthodontics? Yes No				
	Secondary Dental Insurance				
	Co. Name:	-			
	Address:	-			
	CITY STATE ZIP	-			
	Phone #:				
	Insured's ID#:	3			
	Group # (Plan, Local, or Policy #):				
	Insured's Name:				
	Relation: Date of Birth: / /				

	3						
8	33	Child's Fami	ly Information				
Who is accompanying this child today?							
	FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD Do you have Legal Custody of this Child? Yes No						
	How many Brothers/Sisters	How many Brothers/Sisters? Age(s):					
	Mother's Name:						
	Mother's Name: STEP MOTHER _ GUARDIA						
	(CHECK IF SAME AS CHILD'S) H	OME ADDRESS CITY	' STATE ZII				
	() HOME PHONE #						
	MOTHER'S SOCIAL SECURITY #	DATE OF BIRTH	MOTHER'S DRIVERS LIC. #				
	Employer:						
			CONTRACTOR CONTRACTOR				
	EMPLOYER'S ADDRESS	CITY	STATE ZIF				
	Father's Name:	<u> </u>	TEP FATHER GUARDIAN				
	(CHECK IF SAME AS CHILD'S) HO						
	()_ HOME PHONE #						
	Industrial part of the Control of th						
	FATHER'S SOCIAL SECURITY #	/	FATHER'S DRIVERS LIC. #				
	Employer:	Southern Section Section Section (Section Section Sect	_ How Long?				
4	EMPLOYER'S ADDRESS	CITY	STATE ZIP				
	4	Accoun	t Information				
	Person ultimately responsib		i Empormation				
	To Tall the Control of the Control o	ie ioi account					
	Name:		RELATION TO CHILD				
ł	Billing Address:						
d	CITY	STATE	ZIP				
	SOCIAL SECURITY #	DATE OF BIRTH	DRIVERS LIC. #				
1	()	(
	WORK PHONE #: EXT. CELL PHONE #: Payment method: Cash Check						
	D.O	2 120gc 30 100 1000					
	☐ Credit Card - Enter card # a						
	I hereby authorize as benefits directly to the understand I am solely responsinsurance company (if offered	ne provider for ser sible for any balan	vices rendered. I fully				



		Child's Dental	Information			
_		Reason for today's visit: Exam Emergency Consul				
		Is Child in pain? No Yes How Long?	lation			
	1101	Please indicate any of the following problems:				
		☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s				
		☐ Red, swollen or bleeding gums.☐ Sensitive tooth, teeth or gums.☐ Ringing in Ears	☐ Locking Jaw☐ Bad breath			
		☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped too				
	مسيد	Other(s):				
		Does child require pre-medication? 🔲 Yes 🔲 No 🛄 Don't kno	w			
		Previous Dentist: ()				
	Pre Lind	Last Dental exam:/ Last Dental X-rays:	11_			
15	7. TO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Times a day child brushes? Times a week child flosses	;?			
9		Is the child's water fluoridated? Yes No	7 0 0 10			
	Alle (How would you rate the child's smile? Best 1 2 3 4 5 6	7 8 9 10 Worst			
	6					
		Child's Medical History				
77	Is Child taking any of the following me Blood Thinners Tranquilizers I	edications? Pain killers (INCLUDING ASPIRIN) Ritalin Stimulants				
8	Child's Physician:	7 7				
	DOCTOR'S NAME OR CLIN	IIC NAME PHONE# Last Medical Exam://				
	ADDRESS CITY	STATE ZIP				
		the following diseases, medical conditions or procedures? Tonsillitis Y N High/Low Blood Pressure				
		Respiratory Problems Y N Hepatitis Y N Artificial Bones/Joints/Implants				
	Y N Congenital Heart defect Y I	Blood Transfusion(s) Y N Liver/Kidney/Organ Problems				
	Y N Surgeries/Operations Y I	I Leukemia/Anemia Y N HIV+/AIDS/ARC I Diabetes/Hypoglycemia Y N Tuberculosis TB				
	[1] 다른 사람들은 가장 보면 보다 가장 하나 가장 보다	M Hemophilia Y N Psychiatric Problems N Abnormal Bleeding Y N Hyper Active/ADD	(12)			
	Y N Jaw Problems TMJ/TMD Y	Cleft Lip/Palate Y N Fainting/Seizures/Epilepsy				
1	Y N Hearing Problems Y Please list any other medical condition	N Birth Defects Y N Cerebral Palsy n(s) child has or ever had:	· · · · ·			
1						
. 4		llin/Amoxicillin 🔲 Tetracycline 🔲 Dental Anesthetics (Novocaine)				
	☐ Aspirin ☐ Food allergies ☐ Other	10.20	一本			
1	Please rate the child's general health from 1-10:Does child wear contact lenses? _Yes _No					
de	Has this child ever taken the drug Rita		T'			
	Does this child do any of the following?					
			9			
			UPDATE			
	We invite you to discuss with us any que on a friendly, mutual understanding between	(OFFICE USE)				
	Our policy requires payment in full for all made with the business manager. If ac	Initials Date				
	arrangements have been made, you will any other expenses incurred in collecting	Comments				
	I authorize the staff to perform any nece provider to release any information requi	Initials Date				
	I understand the above information and	guarantee this form was completed correctly to the best of my knowledge inform this office of any changes to the information I have provided.	Comments / /			
	Signature	Date / /	Initials Date			
	☐ Parent o		Comments			
			9			