ABOUT YOUR CHILD

Name of Child: _____
First Middle Last

Male ____ Female____ Date of Birth ___/____/_____

Has your child been to the dentist before? Yes _____ No_____
If yes, approximate date of last visit? _____

Does your child need to be premedicated before any dental treatment? Yes_____ No_____

Is your child allergic to any drugs? Yes_____ No_____
If yes, please specify:
_____

Is your child currently under the care of a physician? Yes_____ No_____
If yes, name of physician: _____

Has your child ever had any of the following medical conditions or problems?

Heart Murmur	Yes	No
Heart Problems of any kind	Yes	No
Epilepsy	Yes	No
Rheumatic Fever	Yes	No
Hearing Impairment	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Cancer	Yes	No
Bleeding Problems of any kind	Yes	No
H.I.V. / AIDS	Yes	No
Hepatitis	Yes	No
Hyperactive	Yes	No

Are there any other medical conditions or problems relating to your child? Yes_____ No_____
If yes, please specify:
_____

Guardians Information

Name_____ Date of Birth_____
Name_____ Date of Birth_____
Address_____
City_____ State_____ Zip Code_____ SSN_____-_____-_____
Email _____
Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor
Patient or Guardian's Employer_____
Business Address_____ City_____ State___ Zip Code_____
Whom May We Thank for Referring You? _____

Insurance Information

Name of Insured_____ Relationship to Patient _____
Date of Birth of Insured _____ Social Security # of Insured _____-____-_____
Member Identification_____ Group Number _____
Insured's Employer_____ Phone # _____
Insurance Company Name _____ Phone #_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understanding that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care third party and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ Date _____