

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. If you have questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name Last Name First Name Initial Address City State Zip Home Phone City State School First Name Initial Cell Phone Email School Home Phone City State School First Name First Name First Name First Name First Name First Name Initial School First Name Initial Initial School First Name Initial Initial School First Name Initial Initial Initial School First Name Initial Initial School First Name Initial Initia	Child's Name			Son Son #
State	Last Name	First Name	Initial	Soc. Sec. #
City				
Sex M F Age			Zip	Home Phone
Whom may we thank for referring you? Notify in case of emergency Business Phone Cell Phone Email PRIMARY INSURANCE Person Responsible for Account Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Temail Person Responsible Employed by Business Address Business Final Insurance Company Contract # Addition to Child Additional insurance? □ Yes □ No Subscriber Name Relation to Child Birthdate Address (if different from child) City State Top Home Dontact # Additional insurance? □ Yes □ No Subscriber Mame Address (if different from child) Soc. Sec. # City State Zip Home Phone Coll Phone Email Soc. Sec. # City State Zip Home Phone Coll Phone Email Insurance Email Insurance Email Insurance Email Insurance Company Contract # Soc. Sec. # City State Zip Home Phone Coll Phone Email Subscriber Employed by Business Email Insurance Email Insurance Company Contract # Group # Subscriber Employed by Business Email Insurance Company Phone Contract # Group # Subscriber # Subscriber #	Cell Phone	Email		
Whom may we thank for referring you? Notify in case of emergency Business Phone Cell Phone Email PRIMARY INSURANCE Person Responsible for Account Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Temail Person Responsible Employed by Business Address Business Final Insurance Company Contract # Addition to Child Additional insurance? □ Yes □ No Subscriber Name Relation to Child Birthdate Address (if different from child) City State Top Home Dontact # Additional insurance? □ Yes □ No Subscriber Mame Address (if different from child) Soc. Sec. # City State Zip Home Phone Coll Phone Email Soc. Sec. # City State Zip Home Phone Coll Phone Email Insurance Email Insurance Email Insurance Email Insurance Company Contract # Soc. Sec. # City State Zip Home Phone Coll Phone Email Subscriber Employed by Business Email Insurance Email Insurance Company Contract # Group # Subscriber Employed by Business Email Insurance Company Phone Contract # Group # Subscriber # Subscriber #	Sex □ M □ F Age	Birthdate	_ School	
Notify in case of emergency				
PRIMARY INSURANCE Person Responsible for Account Last Name Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Person Responsible Employed by Business Address Business Email Insurance Company Contract # Subscriber # Name of other dependents under this plan Address (if different from child) Subscriber Name Relation to Child Birthdate Soc. Sec. # ADDITIONAL INSURANCE ADDITIONAL INSURANCE Birthdate Soc. Sec. # City State Distribute Soc. Sec. # City State Distribute Subscriber Name Relation to Child Birthdate Soc. Sec. # City State Distribute Subscriber Employed by Business Phone Business Email Insurance Email Insurance Email Insurance Email Insurance Company Phone Subscriber #	Whom may we thank for referring you?			
PRIMARY INSURANCE Person Responsible for Account Last Name Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Person Responsible Employed by Business Address Business Email Insurance Company Contract # Subscriber # Name of other dependents under this plan Address (if different from child) Subscriber Name Relation to Child Birthdate Soc. Sec. # ADDITIONAL INSURANCE ADDITIONAL INSURANCE Birthdate Soc. Sec. # City State Distribute Soc. Sec. # City State Distribute Subscriber Name Relation to Child Birthdate Soc. Sec. # City State Distribute Subscriber Employed by Business Phone Business Email Insurance Email Insurance Email Insurance Email Insurance Company Phone Subscriber #	Notify in case of emergency			Home Phone
Person Responsible for Account Last Name				
Person Responsible for Account Last Name		PRIMARY I	NSURANCE	
Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Zip Home Phone Demail Derson Responsible Employed by Occupation Business Address Business Email Insurance Email Phone Group # Subscriber # Subscriber # Subscriber # Soc. Sec. # Address Business Phone Business Email Insurance Company Phone Subscriber # Subscriber # Subscriber # Soc. Sec. # City State Zip Home Phone Email Subscriber Employed by Business Email Business Email Insurance Company Phone Subscriber Femail Subscriber Employed by Business Email Insurance Email Insurance Company Phone Subscriber # Subscriber Femail F	Parson Pagnangible for Account			
Address (if different from child) City	reison responsible for Account	Last Name		First Name Initial
Address (if different from child) City	Relation to Child	Birthdate		Soc. Sec. #
Cell Phone Email				
Cell Phone Email	City	State	_ Zip	Home Phone
Person Responsible Employed by Occupation Business Address Business Phone Business Email Insurance Email Insurance Company Phone Contract # Subscriber # ADDITIONAL INSURANCE Is child covered by additional insurance? Yes No Subscriber Name Relation to Child Birthdate Address (if different from child) Soc. Sec. # City State Zip Home Phone Cell Phone Email Subscriber Employed by Business Phone Business Email Insurance Company Phone Contract # Group # Subscriber # Group # Subscriber # Business Phone Business Email Insurance Company Phone Contract # Group # Subscriber #				
Business Address				
Business Email				
Insurance Company				
Contract #				
ADDITIONAL INSURANCE Schild covered by additional insurance? Yes No				
Is child covered by additional insurance?				
Is child covered by additional insurance?		ADDITIONAL	INSURANCE	
Subscriber Name Relation to Child Birthdate				
Address (if different from child) Soc. Sec. # City State Zip Home Phone Cell Phone Email Business Phone Subscriber Employed by Insurance Email Phone Insurance Company Phone Subscriber #	-			
City State Zip Home Phone	Subscriber Name	Relation to Child_		Birthdate
Cell Phone Email Subscriber Employed by Business Phone Business Email Insurance Email Insurance Company Phone Contract # Group # Subscriber #				
Subscriber Employed by Business Phone	City	State	Zip	Home Phone
Business Email Insurance Email Insurance Company Phone Contract # Group # Subscriber #	Cell Phone	Email		
Insurance Company Phone Contract # Group # Subscriber #	Subscriber Employed by			Business Phone
Contract # Group # Subscriber #	Business Email		_ Insurance Email	
	Insurance Company			Phone
Name of other dependents under this plan	Contract #	Group #		_ Subscriber #
The state of the s	Name of other dependents under this plan			
Please complete both sides.			to both eides	

AND DESCRIPTION OF THE PERSON NAMED IN COLUMN 1			
DE	NTIST HEALTHY	GUMS HYGIENIS	57
Acres 1			-
W	DENTAL	. History	(7-
1	What would you like us to do for your child today?		3 .
0	5		1
		dress	-
Mary Cont.		one	T.
		e of last x-rays Floss?	
11	Does your child experience pain or discomfort in the jaw joint?		O
11	Has your child ever experienced a mouth or chin injury?		Santania 1
	Does your child have speech problems?	- 14	The same of
	Has your child ever experienced an adverse reaction during or in a	conjunction with a medical or dental procedure? Y N	1 ,
	Child's habits affecting the mouth or teeth: ☐ Thumb sucking ☐		
Cidale	Other information about your child's dental health or previous trea	· ·	
V			C. All
		II CONTRACTOR OF THE PROPERTY	- (Total)
		L HISTORY	Trend'
	Child's Physician		Total Park
5	Physician's Email		1 ,
	Date of last visit Has your child ha	d any serious illnesses or operations? 🔲 Y 🗀 N	
PER	If yes, describe		-
subject		es, describe	of the last
^		es, give approximate dates	Q
	Has your child ever taken Fen-Phen/Redux? □ Y □ N		
	Check (🗸) yes or no whether your child has had any of the follows:	· ·	
	☐ Y ☐ N AIDS/HIV Positive ☐ Y ☐ N Cough up blood ☐ Y ☐ N Diabetes	☐ Y ☐ N Hemophilia/ Abnormal bleeding ☐ Y ☐ N Shortness of breath ☐ Y ☐ N Sinus problems	S. Park
2	□ Y □ N Asthma □ Y □ N Epilepsy	□ Y □ N Immunizations current □ Y □ N Skin rash	
D	□ Y □ N Atopic (allergy prone) □ Y □ N Fainting	☐ Y ☐ N Kidney disease or ☐ Y ☐ N Spina Bifida	The same of
	□ Y □ N Blood disease □ Y □ N Food allergies	□ Y □ N Liver disease or	- estimates
	□ Y □ N Cancer □ Y □ N Headaches	malfunction Y N Material allergies Y N Tonsillitis	appliful.
des	□ Y □ N Chicken Pox □ Y □ N Hearing Impairment	(latex, wool, metal, chemicals)	
	☐ Y ☐ N Convulsions/Epilepsy ☐ Y ☐ N Heart problems ☐ Y ☐ N Cough, persistent ☐ Describe ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	□ Y □ N Respiratory disease □ Y □ N Other	1
	ovagni potatotit	□ Y □ N Rheumatic/Scarlet fever Describe	V
- Ta	List medications your child is taking, if any:	List drug allergies, if any:	
7			_
I	3		
	Аитно	RIZATION	stoteren
depoint.		the best of my knowledge. I understand that this information will be used by	Separate Separate
	the dentist to help determine appropriate and healthful dental treatment. If	f there is any change in my child's medical status, I will inform the dentist.	3 1
Λ		the dentist all insurance benefits otherwise payable to me for services ns.	()
M	rendered. I authorize the use of this signature on all insurance submission		all Miles
<u> </u>	I authorize the dentist to release all information necessary to secure the pay	yment of benefits. I understand that I am financially responsible for all charges	1
2 2	I authorize the dentist to release all information necessary to secure the pay whether or not paid by insurance.		
EN S	I authorize the dentist to release all information necessary to secure the pay whether or not paid by insurance. Signature	Date	Ĉ
UENTS	I authorize the dentist to release all information necessary to secure the pay whether or not paid by insurance. Signature		
DENI IS	I authorize the dentist to release all information necessary to secure the pay whether or not paid by insurance. Signature	Date unless prior arrangements have been approved. #80-783R1	
S DEN S	I authorize the dentist to release all information necessary to secure the pay whether or not paid by insurance. Signature Payment is due in full at time of treatment, use SmartPractice SmartPractice	Date unless prior arrangements have been approved.	נכפו