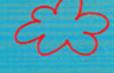


WELCOME





About Your Child

Today's Date:/	/ File #:_	
Child's Name:	FIRST	M.I.
Child's Nickname:		Boy 🖬 Girl
Child's Birthdate:/_	/ Age:_	
School: Grade:		
Child's Home Phone #:()	
Child's SS#:		
Child's Address:	HOME ADDRES	0
	HOWE ADDRES	3
CITY	STATE	ZIP
Referred By:	give address & phone	number.)



Insured's Employer:_

Insurance Information

-	insurance inform	narior
Primary Dental Insu	irance	
Co. Name:		
Address:		
CITY	STATE	ZiP
Phone #:	**************************************	
	or Policy #):	
Insured's Name:	cree-m:30357	
Relation:	Date of Birth:/	
Insured's Employer Does either policy of Secondary Dental In	over Orthodontics? Ye	s 🗆 No
Co. Name:		
Address:		
CITY	STATE	ZIP
Phone #:		
Insured's ID#:		
Group # (Plan, Local,	or Policy #):	
Insured's Name:		
Relation:	Date of Birth:	1

3	Child's Fami	ly Info	mation
Who is accompanying this	child today?		
FULL NAME OF OTHER THAN PAREN Do you have Legal Custon			
How many Brothers/Sister	rs?Age(s):	
Mother's Name:	38	TEP MOTHER	⊇ GUARDIA!
(JI CHECK IF SAME AS CHILD'S) H		STATE	211
() HOME PHONE #	WORK PHONE #		EXT.
MOTHER'S SOCIAL SECURITY #			
EMPLOYER'S ADDRESS	CITY	STATE	ZII
Father's Name:	J (STEP FATHER	J GUARDIA!
(3 CHECK IF SAME AS CHILD'S)			211
HOME PHONE #	WORK PHONE #		EXT.
FATHER'S SOCIAL SECURITY #	DATE OF BIRTH	FATHER'S DR	IVERSUC #
Employer:		_ How Lon	g?
EMPLOYER'S ADDRESS	City	STATE	211



Account Information

Person ultimately resp	consible for account	
Name:		
		RELATION TO CHILD
Billing Address:		
CITY	STATE	ZP
	, , ,	2.5
SOCIAL SECURITY #	DATE OF BIRTH	DRIVERS LIC #
()	()
WORK PHONE #.	EXT. ČELIL PH	ONE #:
Payment method:	☐ Cash ☐ Check	
		37

☐ Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).



1	15	4	5
	5	Child	's Dental Information
101-	Reason for today's visit:	□ Exam □ Emergency	■ Consultation
11011	Is Child in pain? U No U		
$1 \cup 1$	Please indicate d any of		skee Sittlenia). It Steland teeth
		ng gums. Teeth gi	oken Filling(s) Stained teeth rinding Locking Jaw
			in Ears 🗀 Bad breath
		ound the mouth. Broken	Chipped tooth 🗆 Loose tooth
y y	Other(s):	edication? ☐ Yes ☐ No U	1 Dan't know
(0)	Previous Dentist:	edication? Tres Tivo C	/ Don't know
LXXI		/Last Dental	V-raue:
TOL TIT		s? Times a week	
10 % TT	Is the child's water fluorid		Cilia ilosses i
			4 5 6 7 8 9 10 Worst
6		Total Library Laboratory	
6		Child's Medical H	lictory
to Object to the de			
	llowing medications? ☐ Pain killers (izers ☐ Insulin ☐ Muscle relaxers ☐ (timulants
Child's Physician:	zers a risonii a mosco reazer a	Contents	
DOCTOR'S N	AME OR CLINIC NAME	PHONE#	
ADDRESS	GITY STATE ZIP	Last Medical Exam:/	
Does Child have or ever h	ad any of the following diseases,		
Y N Heart Murmur Y N Rheumatic fever	Y N Tonsilitis Y N Respiratory Problems	Y N High/Low Blood Pres Y N Hepatits	sure
Y N Artificial Heart Valves	Y N Asthma/Difficulty Breathing	Y N Artificial Bones/Joints	
Y N Congenital Heart defect Y N Scarlet Fever	Y N Blood Transfusion(s) Y N Leukemia/Anemia	Y N Liver/Kidney/Organ P Y N HIV+/AIDS/ARC	robiems
Y N Surgeries/Operations	Y N Diabetes/Hypoglycemia	Y N Tuberculosis TB	
Y N Cancer/Tumors Y N Chemotherapy	Y N Hemophika Y N Abnormal Bleeding	Y N Psychiatric Problems Y N Hyper Active/ADD	(,**)
Y N Jaw Problems TMJ/TMD	Y N Cleft Lip/Palate	Y N Fainting/Seizures/Epi	epsy
Y N Hearing Problems Places liet any other medical	Y N Birth Defects all condition(s) child has or ever had:	Y N Cerebral Palsy	
ricase list any other model	in containingly critica rias of ever riad.		11.
Is Child allergic to: Latex	☐ Penicillin/Amoxicillin ☐ Tetracycl	line Dental Anesthetics (Novocaine)
☐ Aspirin ☐ Food allergies			
Please rate the child's gene	ral health from 1-10: Does	child wear contact lenses?	⊔Yes ⊔No
	e drug Ritalin? No Yes/How lor	-	
	e following? Thumb/Finger Suck	sing Tongue Thrusting	/Sucking
☐ Heavy Snoring ☐ Mout	h Breathing Lip Sucking/Biting		
■ We invite you to discuss with	h us any questions regarding our services	s. The best Dental health service	es are based UPDATE (OFFICELSE)
on a friendly, mutual underst	anding between provider and patient.		, ,
 Our policy requires payment made with the business ma 	in full for all services rendered at the time on mager. If account is not paid within 90 d	of visit, unless other arrangement tays of the date of service and	no financial
	de, you will be responsible for legal fees,		
I authorize the staff to perfor	m any necessary services needed during nation required to process insurance claim	diagnosis and treatment. I also	
■ I understand the above infor	mation and guarantee this form was com- onsibility to inform this office of any change	pleted correctly to the best of n	ny knowledge / / / vided, Instals Date
Signature	☐ Parent or Guardian ☐ Other	Date / /	Comments
			The state of the s