We are pleased to practice. Please to as completely we'll be glad to with you in ma

Melcone

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 you in maintaining your child's dental health.



PATIENT INFORMATION

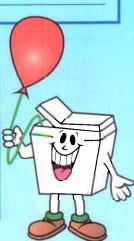
	I A LID	II III ORMAIN	JI1 Date	
Name of Minor/Child.	Last Name	First Name		Initial
Sex M F A	ge Birthdate	Nickname	Hobbies	
Home Address_	Street	City	State	Zip
Mailing Address	Street	City	State	Zip
Person financially responsible		Home Phone	Work Phone	
Whom may we thank for referring	you?			
		INSURANCE		
Eather's /Guardian's Name		Mother's /Guardian's	Name	

Father's/Guardian's Name Address (if different from patient's)	Mother's/Guardian's Name Address (if different from patient's)
Home Phone Work Phone (if different from above) Employer	Home Phone Work Phone (if different from above) Employer
Soc. Sec. #Birthdate Do you have dental insurance coverage for minor/child? Yes No	Soc. Sec. #Birthdate Do you have dental insurance coverage for minor/child?
Plan Name Phone No. Address	Phone NoAddress
Group # Policy # Is your child eligible for treatment under Medical Assistance?	Group # Policy # Child's Medical Assistance I,D. #

DENTAL HISTORY

Date of last visit to a dentist	_ For what service?.	
	YES NO	YES NO
Has child complained about dental problems?		Is fluoride taken in any form?
Does child brush teeth daily?		Any injuries to mouth, teeth, head?
Does child use floss every day?		Any unhappy dental experiences?
Any mouth habits - thumbsucking, nail biting, mo	outh breathing, pacifie	r, sleeping with bottle, etc?
	Disease	Complete Both Cides

Please Complete Both Sides



MEDICAL HISTORY							
Minor/Child's Physician	City/State	Pho	ne				
Date of last physical examination.	Results						
is Minor/Child under care of physician now?	The second secon						
Receiving any medication or drugs?							
Ever been hospitalized?							
Ever had surgery?		Topic Control					
Is there excessive bleeding when cut?							
HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULT		NG2 IE VEG DI EASE CHECK	140				
Al.D.S./H.I.V. Cerebral Palsy	Epilepsy	Kidney Disease	Rheumatic Fever				
Anemia Chicken Pox	☐ Fainting	Liver Disease	Sinus Problems				
Asthma Convulsions	Hearing Problems	Measles	☐ Thyroid Disease				
☐ Bladder Problems ☐ Diabetes	Heart Problems	Mononucleosis	☐ Tuberculosis				
☐ Cancer ☐ Drug/Alcohol Abuse	Hepatitis	Mumps	Other				
EMERGENCY CONTACT							
In the event of an emergency, whom should we contact?							
Name	Relationship	Phone.					
Name	Relationship	Phone.					
	TO BOTTONIO	T-10-10-10-10-10-10-10-10-10-10-10-10-10-					
AUTHOR	IZATIONS						
The information that I have given is correct to the best of my	knowledge. I understand that it w	vill be held in the strictest of	St Common to the state of the s				
confidence, and it is my responsibility to inform this office of	of any changes in my child's med						
dental staff to perform the necessary dental services for my n	ninor/child.						
Signature of Parent/Guardian		Date					
			11/8				
I certify that my minor/child is covered by insurance with	Name of Insurance	Company(les)					
and assign directly to Dr.		all insurance benefits, if any, otherwise payable to me for					
services rendered. I understand that I am financially responsib rize the dentist to release all information necessary to secure							
my insurance submissions, whether manual or electronic.	the payment of benefits, I authorize	ce the use of this signature of t	" L'3				
			444				
Signature of Parent/Guardian		Date					
	E TENED III	EVEN.					
UPDATE							
	(To be a second steal of	at Inter violt\					
	(To be completed a		□No				

If yes, please describe_ Parent/Guardian Signature Date. Dentist Signature Date #21765 - Medical Arts Press 1-800-329-2179