TODAY'S DATE _____

NAME OF PATIENT _____
Last First Nickname

ADDRESS _____
Street Apt. # City State Zip

Home Phone _____ Cell Phone _____ E-mail _____

Age _____ Date of Birth _____ Sex ____

Father's Name _____
Last First Where employed Work #

Home Address _____
Street Apt. # City State Zip

Father's S.S. # _____ Mother's S.S. # _____

Mother's Name _____
Last First Where employed Work #

Home Address _____
Street Apt. # City State Zip

WHOM MAY WE THANK FOR THE REFERRAL?
Family, Friends, Doctor, Yellow Pages, Etc.

List the names of your children _____

Have any of them been seen in this office? _____ Yes _____ No

NAME OF FRIEND OR NEIGHBOR WHO CAN BE REACHED IN CASE OF EMERGENCY

_____ Phone # _____

METHOD OF PAYMENT: _____ CASH _____ CHECK _____ CREDIT CARD

IS PATIENT COVERED BY DENTAL INSURANCE? _____

NAME OF INSURANCE COMPANY _____

POLICY # _____ GROUP # _____

INSURANCE COMPANY ADDRESS _____

EMPLOYER _____

POLICY IN NAME OF : _____ DATE OF BIRTH: _____

DO YOU HAVE SECOND DENTAL INSURANCE _____

NAME AND ADDRESS _____

POLICY # _____ POLICY HOLDER _____ DOB POLICY HOLDER _____

_____ _____
SIGNATURE DATE

As part of total patient care, all new patients in this office will receive a clinical exam and any x-rays the Doctors feel are necessary, unless you request otherwise.

DENTAL HISTORY

Reason for Visit

First Visit _____ Check Up _____ Emergency _____

How long since last visit to dentist? _____

How did child react? _____

Is child taking fluoride? _____ Vitamins? _____

MEDICAL HISTORY

Has child ever been hospitalized? _____ Why? _____

What does child weigh? _____

Is he/she taking medication? _____ What? _____

Does child have allergies? _____ To What? _____

Is child allergic to penicillin? _____ Other Drugs? _____

Past illnesses? _____

UNDERLINE

Does child have a history of: rheumatic fever, heart murmurs, diabetes, unusual bleeding, fainting, kidney/liver involvement, anemia, heart trouble, convulsive disorder, or jaundice?

Any other medical conditions that we should know about?

_____

Pediatrician's Name _____

Address: _____

FOR OFFICE USE ONLY

Doctor's notes _____