Patient Name_____ Sex_____ DOB_____ Home Phone_____ Cell_____ Email_____

Patient Address_____ City_____ State_____ Zip_____ How Long_____ Previous Address (if less than 3 years)_____

Patient SS#_____ Pediatrician_____ Referred by_____

Mother's Information	Legal Custody Yes No	Father's Information	Legal Custody Yes No	Step Parent Information	Legal Custody Yes No
Name		Name		Name	
Occupation		Occupation		Occupation	
Employer	How Long	Employer	How Long	Employer	How Long
Business Phone		Business Phone		Business Phone	
Social Security		Social Security		Social Security	
Birthdate		Birthdate		Birthdate	

Birth Parents: Single Married Divorced Spouse Deceased Separated Nearest Relative (Name/Address/Phone):_____

Dental Insurance Group Name_____ Group #_____ Parent's name who has dental coverage_____

MEDICAL HISTORY

Has your child ever had any of the following:
If YES, please explain below.

YES	NO	
		1. Rheumatic Fever
		2. Hepatitis/Liver Disease/GI Disease
		3. Diabetes
		4. Blood Transfusion
		5. Abnormal Bleeding/Blood Disorder
		6. Epilepsy/Seizures
		7. Tuberculosis
		8. Arthritis
		9. Kidney Disease
		10. Thyroid Disease
		11. Hormonal Dysfunction
		12. Allergies to Drugs and Medications
		13. Hay Fever
		14. Asthma
		15. Tumor/Cancer
		16. Heart Disease
		17. Mumps/Measles/Chicken Pox
		18. Birth Defects
		19. Hospitalization
		20. Pneumonia/Lung Disease
		21. Constant Ear Infection
		22. Anemia
		23. AIDS or AIDS related complex

Explain: Number, date, and duration _____

Additions: Date_____

Reason for dental visit_____

	YES	NO
Is this your child's first dental visit?		
Is your child in good health?		
Does your child have mental or physical handicap? Explain		
Are there problems with hearing, sight, speech, or a learning disorder?		
Did your child have a baby bottle at nap and/or bed time? How long?		
Does your child have a thumb habit or a pacifier?		
Has your child had an unfavorable reaction to medicated treatment?		
Is your child taking any drugs or medicine now? What?		
Does your child have any other medical problems we should know about?		

CONSENT

Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any and/or all dental treatment can be started and completed by the doctor. Our examination may or may not include dental x-rays, depending on your child's specific needs. Photographs for diagnosis, treatrnent planning and teaching may be made.

Consent is hereby given for restorative and/or surgical dental treatment. The restorative materials used may include plastic fillings, plastic sealants and stainless steel crowns. Restorative treatment may include tooth nerve removal when necessary. Surgical treatment may include but not limited to tooth removal and minor gum problems. Local anesthesia and nitrous oxide and oxygen are used routinely as needed for your child's comfort.

No sedative drugs are used without prior consent by parent. If it becomes necessary due to a cooperation problem to control or relax the patient by the use of sedatives, you will be consulted in advance. Physical restraint is not used without a parent's consent unless it is needed to protect the child from self-injury.

I acknowledge that I will be responsible for arranging for payment of any bills incurred on the above child for dental treatment. I understand that all charges are due and payable upon recipt of my monthly statement and all delinquencies are subject to outside collections and that I may be responsible for attorney fees and reasonable collection costs. I also agree to and understand that interest may be assessed on the unpaid balance over sixty (60) days delinquent.

_____
PARENT/GUARDIAN