

Insured's Name: ____

Insured's Employer: _

Relation:_

_Date of Birth: ___ / ___ /_





About Your Child	Child's Family Information		
Today's Date:/ File #:	Who is accompanying this child today?		
Child's Name:	FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD		
LAST FIRST M.I. Child's Nickname: Boy Girl	Do you have Legal Custody of this Child? Yes No		
	II De la Company		
Child's Birthdate: / / Age:	Mother's Name:		
School: Grade:	STEP MOTHER LI GUARDIA		
Child's Home Phone #:()	(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE Z		
Child's SS#:			
Child's Address:	HOME PHONE # EXT.		
	MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC.		
CITY STATE ZIP			
Referred By:(If doctor, please give address & phone number.)	Employer: How Long?		
(, , , , , , , , , , , , , , , , ,	EMPLOYER'S ADDRESS CITY STATE Z		
	Father's Name:		
	□ STEP FATHER □ GUARDIA		
Insurance Information	(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE Z		
Primary Dental Insurance			
Co. Name:			
Address:	FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #		
	Employer: How Long?		
CITY STATE ZIP			
Phone #:	EMPLOYER'S ADDRESS CITY STATE Z		
Insured's SS#:			
Group # (Plan, Local, or Policy #):			
Insured's Name:	Account Informatio		
Relation: Date of Birth://	Person ultimately responsible for account		
Insured's Employer:	Name:		
Does either policy cover Orthodontics? ☐ Yes ☐ No	Billing Address:		
Secondary Dental Insurance			
Co. Name:	CITY STATE ZIP		
Address:	- / /		
CITY STATE ZIP	SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #		
Phone #:	WORK PHONE #: EXT. CELL PHONE #:		
Insured's SS#:	Payment method: U Cash U Check		
acculations and all the September Se			
Group # (Plan, Local, or Policy #):	☐ Credit Card - Enter card # above (if accepted)		



insurance company (if offered at this office).

I hereby authorize assignment of my insurance rights and

Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my

	Child's Dental Information	ation
	Reason for today's visit: Exam Emergency Consultation Is Child in pain? No Yes How Long? Please indicate any of the following problems: Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained Locking Red, swollen or bleeding gums. Reeth grinding Locking Sensitive tooth, teeth or gums. Ringing in Ears Bad brown Blisters/Sores in or around the mouth. Broken/Chipped tooth Loose in Other(s): Does child require pre-medication? Yes No Don't know Previous Dentist: () Last Dental exam: / Last Dental X-rays: / / Times a day child brushes? Times a week child flosses? Is the child's water fluoridated? Yes No How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10	g Jaw eath tooth
6	Child's Medical History	/
	Last Medical Exam://	
Y N Heart Murmur Y N Rheumatic fever Y N Artificial Heart Valves	of the following diseases, medical conditions or procedures? N Tonsillitis Y N High/Low Blood Pressure Y N Respiratory Problems Y N Asthma/Difficulty Breathing Y N Asthma/Difficulty Breathing Y N Asthma/Difficulty Breathing Y N Liver/Kidney/Organ Problems	
Y N Heart Murmur Y N Rheumatic fever Y N Artificial Heart Valves Y N Congenital Heart defect Y N Scarlet Fever Y N Surgeries/Operations Y N Cancer/Tumors Y N Chemotherapy Y N Jaw Problems TMJ/TMD Y N Hearing Problems Please list any other medical condi	Y N High/Low Blood Pressure Y N Hepatitis Y N Hepatitis Y N Asthma/Difficulty Breathing Y N Artificial Bones/Joints/Implants Y N Liver/Kidney/Organ Problems Y N Liver/Kidney/Organ Problems Y N HIV+/AIDS/ARC Y N Diabetes/Hypoglycemia Y N Tuberculosis TB Y N Psychiatric Problems Y N Hyper Active/ADD Y N Cleft Lip/Palate Y N Fainting/Seizures/Epilepsy Y N Cerebral Palsy	
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