WELCOME

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 your child.

		IFORMATION		
Child's Name			Soc. Sec. #	
	First Name	Initial		That Share
Address		co di 10 uniun noli		us bids requi
City				
Cell Phone				
Sex □ M □ F Age				
Grade				
Whom may we thank for referring you?				
Notify in case of emergency			Home Phone	
Business Phone	Cell Phone		_Email	
	PRIMARY	Insurance		
Person Responsible for Account		bert Ho Yo	First Name	la biol
Deletion to Child	Last Name		First Name	Initial
Relation to Child			50C. Sec. #	e Sidamou
Address (if different from child)			Llama Dhana	
City				
Cell Phone				
Person Responsible Employed by				
Business Address				
Business Email				
Insurance Company				
Contract # Name of other dependents under this plan_			_ Subscriber #	
Name of other dependents under this plan_				man S man
	Additiona	L INSURANCE		
Is child covered by additional insurance?				
Subscriber Name				
Address (if different from child)			Soc. Sec. #	
City				
Cell Phone				A STATE OF THE STA
	e production of grad		Business Phone	
		Inquirence Empil		
Subscriber Employed byBusiness Email		Insurance Email		
	Marchael attended in the		Phone	

Dentists Email	What	would you like us to do fo	or your child		L HISTOR			
Deto flast dental care	Forme	r Dentist		Ad	ldress			
How often does your child experience pain or discomfort in the jaw joint?								
Does your child ever experience pain or discomfort in the jaw joint?	Date o	f last dental care		Da	ite of last x-ra	ys		
Has your child ever experienced a mouth or chin injury?								
Does your child have speech problems? Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?	Does	our child experience pair	or discom	fort in the jaw joint?	□Y □N			
Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?	Has yo	our child ever experienced	d a mouth o	r chin injury? \square Y	□N			
Child's habits affecting the mouth or teeth:	Does	our child have speech pr	oblems?					
Child's Physician	Has yo	our child ever experienced	d an adverse	reaction during or ir	conjunction	with a medical or dent	al procedure	? 🗆 Y 🗆 N
Child's Physicians Email Date of last visit	Child's	habits affecting the mou	th or teeth:	☐ Thumb sucking	☐ Nail biting	Other		MIC MIC
Child's Physician	Other	information about your cl	nild's dental	health or previous tr	eatment	Hand		Cell Phone
Child's Physician				Carried Rection		artists .		8/A - 3 C - 9/ C - 262
Child's Physician				MEDIC	и Ністо	DV .		
Physician's Email				AND DESCRIPTION OF THE PERSON				
Date of last visit								
If yes, describe Is your child currently under physician care? Y N If yes, describe Has your child ever had a blood transfusion? Y N If yes, give approximate dates Has your child ever taken Fen-Phen/Redux? Y N Check (/) yes or no whether your child has had any of the following: Y N AlDS/HIV Positive Y N Cough up blood Y N Hemophilia/ Y N Shortness of breath Ahormal Y N Epilepsy Y N Immunizations current Y N Skin rash Y N Astma Y N Fainting Y N Kidney disease or malfunction Y N Atopic (allergy prone) Y N Fainting Y N Kidney disease or malfunction Y N Alogic (allergy prone) Y N Food allergies Y N Liver disease Y N Thyroid disease or malfunction Y N Cancer Y N Headaches Y N Material allergies (latex, wool, metal, chemicals) Y N Concursions/Epilepsy Y N Heart problems Y N Respiratory disease Y N Tonsilitis Y N Cough, persistent Describe Y N Rheumatic/Scarlet fever List medications your child is taking, if any: Authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. Authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.	-							
Is your child currently under physician care? Y N If yes, describe. Has your child ever had a blood transfusion? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N If yes, give approximate dates. Has your child ever taken Fen-Phen/Redux? Y N Hemophilia/ Abnormal bleeding Y N Shortness of breath Ab								
Has your child ever had a blood transfusion? Y N If yes, give approximate dates Has your child ever taken Fen-Phen/Redux? Y N Check (/) yes or no whether your child has had any of the following: Y N AlDS/HIV Positive Y N Cough up blood Y N Hemophilia/ Y N Anemia Y N Diabetes Y N Immunizations current Y N Sinus problems Y N Asthma Y N Epilepsy Y N Immunizations current Y N Skin rash Y N Atopic (allergy prone) Y N Fainting Y N Kidney disease or malfunction Y N Atopic (allergy prone) Y N Fainting Y N Liver disease or malfunction Y N Concer Y N Headaches Y N Material allergies (latex, wool, metal, chemicals) Y N Tonsillitis Y N Convulsions/Epilepsy Y N Heart problems Y N Respiratory disease Y N Other Describe Describe Describe Describe Describe Describe Describe Describe Authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. Lauthorize the use of this signature on all insurance submissions. Lauthorize the dentist to release all information necessary to secure the payment of benefits. Lunderstand that I am financially responsible for all charges whether or not paid by insurance.								
Has your child ever taken Fen-Phen/Redux?								
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Y N AlDS/HIV Positive Y N Cough up blood Y N Hemophilia/ Abnormal bleeding Y N Sinus problems Material allergies (latex, wool, metal, chemicals) Y N Tonsilitits List drug allergies, if any: Y N Active disease Y N Tonsilitits Authorize the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.	Has yo	our child ever taken Fen-F	hen/Redux	POYON				
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List medications your child is taking, if any: List drug allergies, if any: AUTHORIZATION I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.				Heart problems				
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Signature Date			nformation ne	ecessary to secure the pa	ayment of bene	fits. I understand that I am	i financially re	sponsible for all charges
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