Dentistry For Children

Patient Information

Patient's Name____ M F
Patient's Birthdate_______________
Patient's Address_______________________________________
City___________________AZ Zip_______________

1. Parent Guardian name______________________ Phone number__________________
2. Parent Guardian name______________________ Phone number__________________

List other adults you consent to bring in your child for cleaning and/or treatment.

__________________ __________________ __________________

Please sign if you authorize them to sign and agree to any treatment changes on your behalf.

_________________________________ Date________________

Insurance Information

Name of Insurance__________________ Policy holder name_______________D.O.B.______
Member ID or Social Security #________________ Employer_______________________

Any other dental coverage? Y N

How did you hear about us?_______________________________________

Is your child allergic to any medication? Yes No
If yes, please list_______________________________________

Is your child currently taking any medication? Yes No
If yes, please list_______________________________________

Has the Physician ever told you that your child needs an antibiotic before having any dental work?
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Is there anything in your child's previous or present health history which you feel should be brought to our attention?_______________________________________

Does your child have any behavioral or learning disabilities? ____________________
____

Does your child have any of the following?

_____**Heart Murmur**
_____Allergy
_____Bleeding Disorder
_____Asthma

_____**Heart Trouble**
_____Kidney or Liver Problem
_____Speech Problems
_____Epilepsy

_____Diabetes
_____Rheumatic Fever
_____Hyperactivity
_____Medication Allergy
_____Latex Allergy

Parent/Guardian Signature: ______________________________Date________________

Relationship to Child: ______________________________