DATE_____

CHILD'S NAME _____

AGE _____ DATE OF BIRTH _____

PARENT'S NAME _____

RESIDENCE-STREET _____

CITY _____ STATE _____
Zip Code

SCHOOL _____

TELEPHONE: RESIDENCE _____ CELL PHONE _____

FATHER EMPLOYED BY _____ PRESENT POSITION _____ HOW LONG HELD _____

MOTHER EMPLOYED BY _____ PRESENT POSITION _____ HOW LONG HELD _____

REFERRED BY _____

WHO WILL PAY
THIS ACCOUNT _____

REASON FOR VISIT _____

NAME OF DENTAL INSURANCE
COMPANY AND POLICY NUMBER _____

PARENT'S SOCIAL SECURITY NUMBER: FATHER'S _____ MOTHER'S _____

PARENT'S DATE OF BIRTH: FATHER'S _____ MOTHER'S _____

DATE OF LAST MEDICAL EXAMINATION _____

DOES CHILD HAVE OR HAS CHILD EVER HAD:	YES	NO
ANEMIA	_____	_____
DIABETES	_____	_____
HEPATITIS	_____	_____
ALLERGIES	_____	_____
TO PENICILLIN	_____	_____
TO LOCAL ANESTHETIC	_____	_____
ABNORMAL HEART CONDITION	_____	_____
ABNORMAL BLEEDING FROM A CUT	_____	_____
RHEUMATIC FEVER	_____	_____
HEART MURMUR	_____	_____
IS ANY MEDICATION BEING TAKEN NOW	_____	_____

IF SO, WHAT _____

OTHER PHYSICAL CONDITIONS _____

BLOOD PRESSURE (if known) _____/_____/_____

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN NOW..... _____ _____

NAME OF PHYSICIAN _____ TELEPHONE NUMBER _____

SIGNATURE _____ DATE _____
(Parent or Guardian)