

Please take time to fill out this form completely. The more we learn about you the better care we can provide.
We look forward to working with you to maintain a healthy, happy relationship.

Child Information

Today's Date: _____
Patient Name: _____ Nickname: _____
Age: _____ Sex: _____ Patient DOB: _____
Address: _____ City: _____ State/Zip: _____
Soc. Sec #: _____ Phone: _____
School: _____ Grade: _____

Responsible Party for Making Appointments

First Name: _____ Middle Initial: _____ Last Name: _____
Relationship: _____ Home Ph: _____ Cell Ph: _____
Address: _____ City: _____ State/ Zip: _____

Mother:

First Name: _____ Middle Initial: _____ Last Name: _____
DL #: _____ SSN: _____
Home Ph: _____ Cell Ph: _____
Employer: _____ Occupation: _____ Wrk Ph: _____

Father:

First Name: _____ Middle Initial: _____ Last Name: _____
DL #: _____ SSN: _____
Home Ph: _____ Cell Ph: _____
Employer: _____ Occupation: _____ Wrk Ph: _____

Guardian:

First Name: _____ Middle Initial: _____ Last Name: _____
DL #: _____ SSN: _____
Home Ph: _____ Cell Ph: _____
Employer: _____ Occupation: _____ Wrk Ph: _____

Best Time to Call:

Parent/ Guardian: _____ Day(s): _____ Time: _____
Parent/ Guardian: _____ Day(s): _____ Time: _____
Parent/ Guardian: _____ Day(s): _____ Time: _____

Insurance

Primary Insurance:

Subscriber Name: _____ ID Number (On Insurance Card): _____
 Birthdate: _____ SSN: _____
 Employer: _____ Occupation: _____
 Insurance Company: _____ Group No. (Plan or Policy): _____

Secondary Insurance:

Subscriber Name: _____ ID Number (On Insurance Card): _____
 Birthdate: _____ SSN: _____
 Employer: _____ Occupation: _____
 Insurance Company: _____ Group No. (Plan or Policy): _____

Child's Health History

How often does your child brush per day?

How often does your child floss a day?

Has your child ever had any of the following:

Asthma:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis:	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/ AIDS:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hemophilia:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abnormal Bleeding:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stomach, Liver or Kidney Problems:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Defect:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Convulsions/ Epilepsy:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Handicap/ Disabilities

If so, please explain: _____

Please explain any other health issue your child may have: _____

