CHILD PATIENT INFORMATION

We apologize for the time and effort it takes to answer all of these questions but we must have all the information that is applicable before we begin treatment. Please be assured all information is held in complete confidence. If there are any questions or problems please discuss them with us.

Please complete all information and sign where indicated.

Child's Name _____ Sex ____ Date of Birth _____ Age _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you to our office?_____

Father's Name _____ Father's (or Mother's) Address if different _____

Home Phone if different _____ Business Phone _____ Ext. _____ Social Security Num. _____ Date of Birth _____

Father Employed by _____ Employer's Address _____

Occupation or Present Position _____ How long _____ Dental Insurance Carrier _____ Plan I.D. # _____

Mother's Name _____ Mother Employed by _____ Employer's Address _____

Business Phone _____ Occupation or Present Position _____ Yrs. Held _____ Name of Dental Insurance Carrier _____

Mother's Social Security No. _____

Name of financially responsible party_____

PREVIOUS DENTAL EXPERIENCE

Date of last dental exam _____ Name of previous dentist _____ City _____ State _____ Phone # _____

Reason for leaving? _____ Would you like us to request previous x-rays?_____

Previous dental experience, positive and negative _____ Injuries to the mouth or teeth, Mouth habits(thumbsucking) _____

What aspects of your last dental office did you NOT like? _____

Is there anything our office can do that would make your child's dental experience more pleasant _____

As parent, guardian or their designated representative I hereby grant permission for the dental treatment of the child named above including the administration of local anesthetic as necessary to insure comfortable treatment.

Signed _____