

WELCOME! WE'D LIKE TO GET TO KNOW YOUR FAMILY BETTER

This personal information of your child will help us give him/her our best professional help. All information on this form is for our records only and will be considered confidential.

Are you aware of your child having any particular dental problems? _____

Is your child having any discomfort or pain? _____

Is this your child's first visit to the dentist? _____ If not, how long since last examination? _____

What was done for your child at that time? _____

Please indicate any serious illness or medical problems that you feel we should know about your child (i.e. Rheumatic fever, diabetes, any heart problems, bleeding problems, etc.) _____

Is your child allergic to any of the following medications?

Penicillin

Codeine

Aspirin

Novocaine

Anesthetics

Other drugs

Who is your child's physician? _____

The date of your child's last medical check-up: _____ Is your child under any medical treatment at the present time? _____

Whom may we thank for recommending our office to you? _____

Child's name _____ Date & year of birth _____

Home address _____ City _____

State _____ Zip _____ Home phone _____

School _____ Grade _____

Father's name _____ Where does he work? _____ Phone _____

Mother's name _____ Where does she work? _____ Phone _____

Dental Insurance? Y N Ins. Company _____ Group # _____

Responsible person (if other than parent) _____

PERMISSION FOR TREATMENT AND PROMISE OF PAYMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I also agree to accept full responsibility for the payment of all fees associated with those procedures or drugs, and all costs incurred in the collection of those fees.

PATIENT (PARENT) _____ DATE _____

DOCTOR _____ DATE _____