CHILD *(Ages 2-17 Only)*

Child's Last Name_____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Birthdate _____/_____/_____ Age _____ Sex _____ Home Phone # (_____) _____-_____

Father's Name _____ DOB _____ Soc. Sec. Number _____-____-_____

Employed by _____ Work Phone _____ Cell Phone _____

Mother's Name _____ DOB _____ Soc. Sec. Number _____-____-_____

Employed by _____ Work Phone _____ Cell Phone _____

Name of Medical Doctor _____ Phone _____

Who is financially responsible for this bill? _____

Address _____

Whom may we thank for referring you to us? _____

DOES THE CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes ……	☐	☐	Glaucoma ……	☐	☐
Epilepsy ……	☐	☐	Blood Transfusion ……	☐	☐
Hepatitis ……	☐	☐	Seizures ……	☐	☐
Rheumatic Fever ……	☐	☐	Sickle Cell Disease ……	☐	☐
Abnormal Heart Rate ……	☐	☐	Allergic to:		
Cancer or Tumor ……	☐	☐	Antibiotics / Penicillin ……	☐	☐
Valvular Disease ……	☐	☐	Local Anesthetic ……	☐	☐
Abnormal Bleeding ……	☐	☐	Other Medications ……	☐	☐
High Blood Pressure ……	☐	☐	Please specify _____		
Emphysema / Asthma ……	☐	☐	_____		
Tuberculosis ……	☐	☐	Other Illnesses / Conditions / or		
Chemotherapy ……	☐	☐	Current Medications ……	☐	☐
History of ADHD ……	☐	☐	Please specify _____		
Autism ……	☐	☐	_____		

Is there anything you would like for us to know to help us care for him/her better? _____

_____

The undersigned, hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature here authorizes my dentist to submit claims for benefits, services rendered, or to be rendered without obtaining my signature. This holds true for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

To the best of my knowledge, all of the preceding answers are true. If there is ever a change in my child's health, or if the medicines change, I will inform the dentist at the next appointment without fail.

Signed _____ Relation to Child _____ Date_____

_____ I ACKNOWLEDGE THAT I WILL BE PERSONALLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY MY INSURANCE.