

Date \_\_\_\_\_

Patient's name \_\_\_\_\_ Nickname \_\_\_\_\_ Date of birth \_\_/\_\_/\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_ E-mail: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of child's school \_\_\_\_\_ Grade \_\_\_\_\_  
With whom does the child live? \_\_\_\_\_

Mother's name \_\_\_\_\_ SS# \_\_/\_\_/\_\_ Date of birth \_\_/\_\_/\_\_  
Residence address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business address \_\_\_\_\_ Business phone \_\_\_\_\_

Father's name \_\_\_\_\_ SS# \_\_/\_\_/\_\_ Date of birth \_\_/\_\_/\_\_  
Residence address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business address \_\_\_\_\_ Business phone \_\_\_\_\_

Person responsible for account \_\_\_\_\_  
Subscriber of insurance \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Whom may we thank for recommending our office to you? \_\_\_\_\_

Purpose of visit and any special dental concern \_\_\_\_\_

**General Health**

Have you been a patient in a hospital during the past 2 years? Yes No  
Have you been under the care of a physician during the past two years? Yes No  
Have you taken any kind of medicine or drugs during the past year? Yes No  
Are you allergic to penicillin, codeine, or any other drugs or medicine? Yes No

List allergy please \_\_\_\_\_

Have you ever had excessive bleeding requiring treatment? Yes No

Circle any of the following that you have had:

- |                          |              |                       |
|--------------------------|--------------|-----------------------|
| Heart trouble            | jaundice     | arthritis             |
| Congenital heart lesions | asthma       | stroke                |
| Heart murmur             | cough        | epilepsy              |
| High blood pressure      | diabetes     | psychiatric treatment |
| Anemia                   | tuberculosis | sinus trouble         |
| Rheumatic fever          | hepatitis    |                       |

(Women) Are you pregnant now? Yes No

Have you had any other serious illnesses? Yes No

List them please \_\_\_\_\_

I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of treatment unless prior arrangements have been made. All accounts must be paid within 30 days. In the event that your account becomes delinquent, finance charges will accrue and the patient is responsible for all collection fees. A fee of \$50.00 will be charged for failed appointments without 24 hours notice.

Responsible adult's signature \_\_\_\_\_