WAR COME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

good oral care that will enable your child to h	TO THE STATE OF TH
Tell Us About Your Child Today's Date:	Person Responsible For Account Name: Relation:
Child's Name: LAST FIRST MI	Billing Address:
Nickname: Male Female	Dining Address.
	CITY STATE ZIP
Child's Birthdate:/ Child's Age:	Hm #: ()DL #:
School: Grade:	Employer:
Child's Home #: () SS #:	Wk #: ()Ext: SS #:
E-mail Address:	
Child's Home Address:	Who is responsible for making appointments? Name:
CITY STATE STATE ZIP	Wk #: (Ext: Hm #: ()
Who Is Accompanying The Child Today?	Primary Dental Insurance
Name: Relation:	
Do you have legal custody of this child?	Insurance Co. Name: Insurance Co. Address:
Whom may we Thank for referring you?	Insurance Co. Phone #: ()
Other family members seen by us:	Group # (Plan, Local, or Policy #):
Office running members seen by us.	Policy Owner's Name:
	and the second s
Previous / Present Dentist:	Relationship to Patient:
Last Visit Date:	Policy Owner's Birthdate:/ /_ SS #:
Parent's Marital Status: Single Widowed Separated	Policy Owner's Employer:
Manne Land Commence of the Com	Employer's Address:
) CAN THE TAXABLE TO	Orthodontic Coverage? Yes No
Mother's Information: Step Mother Guardian	Secondary Dental Insurance
Name: Birthdate://	Insurance Co. Name:
Wk #: () Ext: Hm #: ()	Insurance Co. Address:
Employer:	Insurance Co. Phone #: ()
SS #: DL #:	Group # (Plan, Local, or Policy #):
Eathor/s Informations Co. 1. Co.	Policy Owner's Name:
Father's Information: Step Father Guardian Name: Birthdate:/	Relationship to Patient:
	Policy Owner's Birthdate:/_/ SS#:
Wk #: Ext: Hm #:	Policy Owner's Employer:
Employer:	Employer's Address:
SS #: DL #:	Orthodontic Coverage?
	en continuent de la con

	ild to the	Has the child ever had any of the
dentist today?		following medical problems?
		Y N Abnormal Bleeding Y N Handicaps / Disabilities
as the child ever had a serious/difficult pro	oblem associated	Y N Allergies to any drugs Y N Hearing Impairment Y N Any Hospital Stays Y N Heart Murmur
with previous dental work?	Yes No	Y N Any Operations Y N Hemophilia
the child's water fluoridated?	Yes No	Y N Artificial Bones / Joints / Y N Hepatitis
the child taking fluoridated supplements?	The state of the s	Valves Y N HIV+ / AIDS
	Macrophic Specification	Y N Asthma Y N Kidney / Liver Problem Y N Cancer Y N Rheumatic / Scarlet Feve
the child ever had any pain / tenderne joint (TMJ / TMD)?	ss in his / her jaw Ves No	Y N Congenital Heart Defect Y N Sickle Cell Disease/Trai Y N Convulsions / Epilepsy Y N Tuberculosis (TB)
es the child brush his / her teeth daily?	Yes No	Y N Diabetes
s his / her teeth daily?	☐ Yes ☐ No	Please discuss any serious medical problems that the
d's Physician:		child has had:
ne #: () Date of Last	Section Control of the Control of th	
ne child currently under the care of a physi		THE REPORT OF THE PARTY OF THE
District Control of the Control of t		
Good Fair Poor	nealth:	Q. Marie Hilliam Control of the
	Yes No	Does/did the child have any of the
your child ever taken Phen-Fen? (Also known as Redux or Pondimin) If so, when?		following habits?
se list all drugs that the child is current	tly taking:	Y N Lip Sucking / Biting Y N Nail Biting
		Y N Nursing Bottle Habits Y N Thumb / Finger Sucking
		Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA,
		the CDC and the ADA.
ase list all drugs/materials that the chil	d is allergic to:	- CHERRETERING CONTRACTOR CONTRAC
		Neighbor or Relative not living with you.
		Name Phone ()_
ummunum.		Address
		The state of the s
TO THE REST		City State Zip
O BY ON THE SALE		City State Zip
Understand that the informat	MONAT.	status. I authorize the dental staff to perform the necessary
I understand that the informat	tion that I have given	status. I authorize the dental staff to perform the necessary
is correct to the best of my knowledge	tion that I have given e, that it will be held in	status. I authorize the dental staff to perform the necessary dental services my child may need.
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is correct to the best of my knowledge the strictest of confidence and it is informthis office of any changes in	tion that I have given e, that it will be held in my responsibility to nmychild's medical	status. I authorize the dental staff to perform the necessary dental services my child may need. Signature of parent or guardian Date
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FORM #DDS-2C3

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HAPPY WELCOME