

0	Today's Date:	Child's Home Ph	none #: ()_		Social Security #:		
S to E	Child's Name:						
Tell Us About our Chilc	Last Nickname:	First	ale 🗆 Female Scho	ool:		Grade:	
Tell Ab Your	Child's Home Address:						
		Street		City		State	Zip
Who Is Accompanying The Child Today?	Name:			Relatio	on:		
riy da	Do you have legal custody of this child?	☐ Yes ☐ No	Is the child adop	oted? 🗆 Yes 🗆	No I	s the child in a foster hon	ne? 🗆 Yes 🗅 No
2 E C	Whom may we Thank for referring you?		_ Other siblings se	en by us:			
축 다 다		Neighb	oor or Relative r	ot living w	rith you		
> § t	His / Her Name:	Relation:	Work Pho	one #: ()_		Home Phone #: ()_	
Acc	Address:	Street		City		State	Zip
		Sireer		City		Sidle	Zip
	Parent's Ma	rital Status: 🗖 Marrie	d Divorced DS	eparated 🗅 \	Widowed 🗆 Rema	rried 🗅 Single	
	Mother: 🗆 Step Mother 🗅 Guardian	Birthdate:/_	/ Home Pl	none #: (		Work Phone #: ()	
_	Name:	Sc	ocial Security #:		D	Priver's License #:	
s, 10.	Address:	Street		City		State	Zip
Parent's Information	Employer:	Officer					
a P	Father: Step Father Guardian	Birthdate: /	/ Home Pl	oone #· I		Work Phone #: ( )	
<u> </u>	Name:					Priver's License #:	
	Address:		Jeidi 0000111) 111				
	Employer:			City	Le	State ength of Employment:	Zip
0 +	Name:		Relationsh	ip:		Social Security #:	
rie z	Billing Address:		- September 51				
Person Responsible for Account	Work Phone #: ()	Street	)	City _ Employer: _		State Driver's License #:	Zip
Pe SSP SP		Who is	s responsible for mo	ıking appoint	ments?		
22	Name:	Work Phone #: (	J	Home Phone	#: ()	Best time to	call:
	(H. 1. 1. 0. 5. V. 5. V.	Y .	0.10.00	v 511			0 DV DV
	Medical Coverage? ☐ Yes ☐ No		Dental Coverage?		C #/pl 1	Orthodontic Covera	
	Insurance Co. Name:	Ph	one #: ()_		Group # (Plan, Loc	cal, or Policy #):	
	Insurance Co. Address:	PO Box/Street		City	D.: .	State	Zip
	Policy Owner's Name:						
e ior	Policy Owner's Birthdate://	_ Social Security #:			Policy Owner's Em	nployer:	
Insurance Information	Employer's Address:	Street		City		State	Zip
sui	Medical Coverage? □ Yes □ No		Dental Coverage? 🗆	Yes □ No		Orthodontic Covera	ge? 🗆 Yes 🗆 No
三重	Insurance Co. Name:	Ph	one #: ()_		Group # (Plan, Loc	cal, or Policy #):	
	Insurance Co. Address:	PO Box/Street		City		State	Zip
	Policy Owner's Name:	FO BOX/Street		_ Relationsh	ip to Patient:	Sidle	Zip -
	Policy Owner's Birthdate://	Social Security #:			Policy Owner's Em	nployer:	

City

Employer's Address:

Street

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?   Yes   No   Has the child experienced problems with previous dental work?   Yes   No   Is the child swater fluoridated?   Yes   No   Is the child swater fluoridated?   Yes   No   Previous / Prevent Dentist.   Previous / Prevent Dentist.   What did you like most about any dentist you have seen?   Does the child brush his / her teeth daily?   Yes   No   Previous / Prevent Dentist.   What did you like most about any dentist you have seen?   Does / did the child have any of the following habits?   Y N Braast Fed   Y N Morth Breather   Y N Thumb / Finger Sucking Y N Cheving on Objects   Y N Nail Bitting   Y N Tongue / Cheek Bitting Y N Tongue / Cheek Bitting Y N Clenching / Grinding Teeth   Y N Naving Bottle Habits   Y N Tongue / Cheek Bitting Y N Tongue / Cheek Bitting Y N Tongue / Cheek Bitting Y N Speech Problems   Y N Tongue / Cheek Bitting Y N Low Bload Pressure    Child's Physician:			ac the	a child over had any nain / tondorna	es in his /	ha	ione ioint /TAAL / TAADIS	Voc. D No.				
Is the child's water fluoridated?   Yes   No   Is the child taking fluoridated supplements?   Yes   No   Floss his / her teeth daily?   Yes   No   Previous / Previous / Previous / dentist?   Yes   No   Floss his / her teeth daily?   Yes   No   Previous / Previous / Previous / Previous / Previous / dentist?   Yes   No   Previous / Previous								ies 🗆 No				
Does the child brush his / her teeth daily?   Yes   No   Floss his / her teeth daily?   Yes   No   Previous / Previous / Previous / Previous dentist?   Date of Last Visit:   Now   Now   Date of Last Visit:   Now   Now   Date of Last Visit:   Now   Now   Date of Last Visit:   Date Of La												
Previous / Present Dentist:												
What did you like most about any dentist you have seen?    Does / did the child have any of the following habits?   Y N Breast Fed												
What did you like most about any dentist you have seen?   Least about?			Plance	Circle			Date of I	Last Visit:				
Does / did the child have any of the following habits?  Y N Breast Fed Y N Mouth Breather Y N Thumb/Finger Sucking Y N Chewing on Objects Y N N Tongue/Cheek Biting Y N Tongue/Cheek Biting Y N Tongue/Cheek Biting Y N Clenching/Grinding Teeth Y N Nursing Bottle Habits Y N Tongue Thrust Y N Lip Sucking / Biting Y N Speech Problems Y N Used Pacifier    Child's Physician:												
Y N Breast Fed Y N Mouth Breather Y N Thumb/Finger Sucking Y N Chewing on Objects Y N Nail Bitting Y N Tongue/Cheek Bitting Y N Clenching/Grinding Teeth Y N Nursing Bottle Habits Y N Tongue Thrust Y N Used Pacifier  Child's Physician:  Address:    Phone #:		W	hat di	d you like most about any dentist you have se	en?			Least about? _				
Y N Chewing on Objects Y N Nail Bitting Y N Tongue / Cheek Bitting Y N Clenching / Grinding Teeth Y N Nursing Bottle Habits Y N Tongue Thrust Y N Lip Sucking / Bitting Y N Speech Problems Y N Used Pacifier  Child's Physician: Phone #: Date of last visit: Address: Street   Date of last visit: Phone #: Phone Phon	7			Doe	s / did the	e ch	ild have any of the following	ng habits?				
Y N Clenching/Grinding Teeth Y N Nursing Bottle Habits Y N Tongue Thrust Y N Lip Sucking/Bitting Y N Speech Problems Y N Used Pacifier  Child's Physician: Phone #: Date of last visit: Address:    Address:   Street   Date of last visit:   Date		Υ	N	Breast Fed	Υ	N	Mouth Breather		Υ	N	Thumb/Finger Sucking	
The substitution of the state o		Υ	N	Chewing on Objects	Y	N	Nail Biting		Υ	N	Tongue/Cheek Biting	
Child's Physician:		Υ	N	Clenching / Grinding Teeth	Υ	N	Nursing Bottle Habits		Υ	N	Tongue Thrust	
Child's Physician:	人	Y	N	Lip Sucking/Biting	Υ	N	Speech Problems		Υ	N	Used Pacifier	
Address:   Street   Street   City   State   Zip		<u>-</u>	11/ D					D . (I		100		
Please describe the care of a physical health: Good Fair Poor Are Immunizations Current? Yes Please list all drugs that the child is currently taking:  Please list all drugs and/or other things that cause the child allergic reactions:  Anything you would like to discuss with the Doctor in private? Yes No  Has the child had/experienced any of the following:  Y N Abnormal Bleeding Y N Diabetes Y N Low Blood Pressure Y N AIDS/HIV+ Y N Epilepsy Y N Lupus Y N Allergies Y N Handicaps/Disabilities Y N Measles Y N Anemia Y N Hearing Impairment Y N Mitral Valve Prolapse Y N Any Hospital Stays/Operations Y N Heart Murmur Y N Mononucleosis Y N Asthma Y N Hemophilia Y N Reputitis Y N Scarlet Fever Y N Blood Transfusion Y N Hegatitis Y N Scarlet Fever Y N Cancer Y N High Blood Pressure Y N Cicken Pox Y N Hives Y N Skin Rash Y N Congenital Heart Defect Y N Kidney Problems Y N Tonsillitis Y N Convulsions Y N Liver Problems Y N Tuberculosis (TB)		Ch	illa's P	nysician:			_ Phone #: ()	Date of las	st vis	sit: _		
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Please list all drugs that the child is currently taking:  Please list all drugs and/or other things that cause the child allergic reactions:  Has the child had/experienced any of the following:  Y N Abnormal Bleeding Y N Diabetes Y N Low Blood Pressure Y N AIDS/HIV+ Y N Epilepsy Y N Lupus Y N Allergies Y N Handicaps/Disabilities Y N Measles Y N Anemia Y N Hearing Impairment Y N Mitral Valve Prolapse Y N Any Hospital Stays/Operations Y N Heart Murmur Y N Mononucleosis Y N Asthma Y N Hemophilia Y N Rheumatic Fever Y N Blood Transfusion Y N Hepatitis Y N Scarlet Fever Y N Cancer Y N High Blood Pressure Y N Sickle Cell Anemia Y N Hives Y N Skin Rash Y N Congenital Heart Defect Y N Kidney Problems Y N Tonsillitis Y N Tonsillitis		Ple	ease	describe the child's current physical l	health: 🗆	God	od 🗖 Fair 🗖 Poor	Are Imr	nun	izat	tions Current?  Yes N	
Anything you would like to discuss with the Doctor in private?		Ple	ase lis	t all drugs that the child is currently taking:							110000	
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Y N Convulsions Y N Liver Problems Y N Tuberculosis (TB)			N		Y				· ·			
			N		· ·				·			
Please discuss any serious medical problems the child experiences/ed:										14	Tuberculosis (Tb)	
		Ple	ease	discuss any serious medical problem	s the child	ex	periences/ed:					
		_						Augustus Au				
	Y	la	affirm	that the information I have given is corn	ect to the b	est	of my knowledge. It will be h	eld in the strictest o	conf	iden	ice and it is my responsibi	
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsible					s medical s	tatu	s. I authorize the dental statt	to perform the nec	ess	ary	dental services my child m	
to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child n		110	.cu. 11	ty memod of payment will be								
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