THIS FORM MUST BE FILLED OUT BY A PARENT OR LEGAL GUARDIAN
THIS LEGAL DOCUMENT MUST BE FILLED OUT IN INK

In order to keep our records accurate and updated, please fill out the following. Your cooperation is greatly appreciated.

Date:________________ Child's Full Name:______________________________________Date of Birth__________Age:_____

Address:____City:_______________State:_________________Zip:_____________

Home # : ____________________ Mom Cell #: _____________________ Dad Cell#: _____________________

Would you like to sign up for our new email appointment reminders? Write your email here: ______________________________

Would you like to stay opted-in for text messages? *(circle one)* **Yes (Keep me signed up for text messages) NO (I do not want to receive text messages)**

(If your insurance information has NOT changed, please proceed to the medical information section).

New Insurance Information

Policy Holder's Name: _____________________ Employer: _____________________ Policy Holder's Birthdate: ____________

SS#: ___________ Employee ID#:______________ Name of Insurance Comp:___________ Insurance Phone # _____________

Insurance Address:____ Group #:_______________________

Please check all that apply.

- ❒ Abnormal Bleeding/Hemophilia
- ❒ ADD/ADHD
- ❒ Adenoids Removed
- ❒ Anemia
- ❒ Artificial Heart Valve
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Autism/PDD/Aspergers
- ❒ Cancer
- ❒ Cerebral Palsy
- ❒ Chicken Pox
- ❒ Complications from sedation or general anesthesia or anesthetic solutions
- ❒ Congenital Heart Disease
- ❒ Diabetes
- ❒ Down Syndrome
- ❒ Ear Tubes
- ❒ Epilepsy/Seizures
- ❒ Frequent Ear/Throat Infections
- ❒ Handicaps/Wheelchair/Walker
- ❒ Heart Murmur
- ❒ Hearing Loss/Speech Problems
- ❒ Hepatitis
- ❒ High/Low Blood Pressure
- ❒ HIV/Aids
- ❒ Hives/Skin Rash
- ❒ Kidney/Liver Disorders
- ❒ Latex Allergy
- ❒ Learning Disability
- ❒ Lung/Breathing Problems
- ❒ Lupus
- ❒ Measles
- ❒ Mitral Valve Prolapse
- ❒ Mononucleosis
- ❒ Pregnancy
- ❒ Prosthetics
- ❒ Psychiatric Care
- ❒ Rheumatic Heart Disease
- ❒ Scarlet Fever
- ❒ Sickle Cell/Anemia
- ❒ Tobacco Use
- ❒ Tonsils Removed
- ❒ Transfusions
- ❒ Tuberculosis
- ❒ Other ___________________

❒ Any hospital stays: Month: ________ Year: ________ Reason: ______________________________
❒ Any surgeries/procedures: Month: ________ Year: ________ Reason: ______________________________
❒ Placement of metal, pins, and or screws in your body: Month: _________ Year: __________

Please list all drugs/things the child is allergic to: ____

Please list all medications your child is taking at this time and the reason: ______________________________________

____

Discuss any medical/dental problems or concerns your child has at this time: ________________________________

____

Is your child seeing an Orthodontist? _______ If Yes, what is the name of the Orthodontist? ____________________________

If your child is here today for the check-up, they will receive the following services: **Exam, Prophylaxis, Fluoride and X-Rays.**

FOR THE PRIVACY OF OUR PATIENTS AND STAFF, WE ASK THAT NO VIDEOS OR PHOTOS BE TAKEN IN OUR OFFICE. THANK YOU FOR YOUR COOPERATION.

Signature of parent/legal guardian ____ Date: ___________________________

Relationship to child: ____