

**Thompson Ray Bogert, D.D.S.**

1220 Clear Lake City Blvd.

Houston, Texas 77062

**THIS FORM MUST BE FILLED OUT BY A PARENT OR LEGAL GUARDIAN**

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

Date \_\_\_\_\_ Child's Full Name \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_

Father: Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Mother: Work# \_\_\_\_\_ Cell# \_\_\_\_\_

**INSURANCE INFORMATION:**

Has your dental insurance information **CHANGED**? Yes \_\_\_\_\_ No \_\_\_\_\_ (If **NO**, please skip the next 4 lines and proceed to the medical information section)

If **YES**: Policy Holder's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_ Employee ID# \_\_\_\_\_

Name of Insurance Comp: \_\_\_\_\_ Insurance Phone # \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Group # \_\_\_\_\_

**MEDICAL INFORMATION:**

Does your child now have or ever had any of the following: (**PLEASE CIRCLE IF YES OR NO**)

- |     |                         |     |                              |     |                               |
|-----|-------------------------|-----|------------------------------|-----|-------------------------------|
| Y N | ARTIFICIAL HEART VALVE  | Y N | LUPUS                        | Y N | HIVES/SKIN RASH               |
| Y N | CONGENITAL HEART DEFECT | Y N | DIABETES                     | Y N | SCARLET FEVER                 |
| Y N | HEART MURMUR            | Y N | KIDNEY/LIVER PROBLEMS        | Y N | MEASLES                       |
| Y N | MITRAL VALVE PROLAPSE   | Y N | SICKLE CELL TRAIT            | Y N | ADD/ADHD                      |
| Y N | RHEUMATIC FEVER         | Y N | ASTHMA                       | Y N | PSYCHIATRIC CARE              |
| Y N | HIGH/LOW BLOOD PRESSURE | Y N | TUBERCULOSIS                 | Y N | AUTISM/HANDICAPS/DISABILITIES |
| Y N | PROSTHETICS             | Y N | MONONUCLEOSIS                | Y N | HEARING IMPAIRMENT            |
| Y N | ARTIFICIAL JOINTS       | Y N | ANEMIA                       | Y N | CONVULSIONS/EPILEPSY          |
| Y N | AIDS/HIV+               | Y N | ABNORMAL BLEEDING/HEMOPHILIA | Y N | PREGNANCY                     |
| Y N | CANCER                  | Y N | CHICKEN POX                  | Y N | TOBACCO USE                   |
| Y N | HEPATITIS               |     |                              |     |                               |

Y N ANY HOSPITAL STAYS: MONTH: \_\_\_\_\_ YEAR: \_\_\_\_\_ REASON: \_\_\_\_\_

Y N ANY SURGERIES/PROCEDURES: MONTH: \_\_\_\_\_ YEAR: \_\_\_\_\_ REASON: \_\_\_\_\_

Y N BROKEN/FRACTURED BONES: MONTH: \_\_\_\_\_ YEAR: \_\_\_\_\_ REASON: \_\_\_\_\_

Y N 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: \_\_\_\_\_

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

Signature of parent/legal guardian \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_