WEE CARE DENTAL, P.C.

Specializing in
Infants • Children • Adolescents

PATIENT INFORMATION

RICK J. MEYERS, D.D.S.

702 East Bell Road, Suite 116
Phoenix, Arizona 85022

Today's Date _____

Child's Name _____ Prefers To Be Called _____

Date of Birth _____ Age _____ Male ❑ Female ❑

Name and Ages of Brothers and Sisters _____

_____

Have We Seen A Family Member Here Before _____Yes _____No

Child's Former Dentist _____ Address _____ Phone _____

Child's Physician _____ Address _____ Phone _____

Father's Full Name _____ DOB _____ SS# _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Father's Employer _____ Occupation _____

Business Address _____ Business Phone _____

Mother's Full Name _____ DOB _____ SS# _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Mother's Employer _____ Occupation _____

Business Address _____ Business Phone _____

Referred By _____

Nearest Friend or Relative in Phoenix _____

Address _____ Phone _____

Insurance Company Name _____ Name of Subscriber _____

Subscriber Date of Birth _____ Relationship To Patient _____

Employer _____ ID# _____

Insurance Address _____ City _____ Zip _____

Insurance Phone _____ Group Number _____

I understand that I am responsible for the payment of any charges for dental services rendered to the above child. We may assist you in submitting your insurance claim. However, you are responsible for payment of your account, not the insurance company. In the event your account is referred to an attorney for collection, you agree to pay for reasonable attorney's fee and court costs incurred in connection there with. All services and their estimated cost will be discussed with me before such services are rendered. Returned Checks are subject to Finance Charges.

Signature _____

Date _____ Relationship _____

(OVER)

PATIENT'S HEALTH HISTORY

Your answers to these questions are of great value to us in having a better understanding of your child.

		Check One Yes	No
1.	Is your child in good health? If no, please explain. _____	❑	❑
	_____		
2.	Has your child had any history of epilepsy: cerebral palsy: heart trouble: allergies: diabetes: asthma: kidney, liver or thyroid disorders: mental retardation, or prolonged bleeding? (if yes, underline condition) __	❑	❑
3.	Which childhood diseases has your child had? (Please underline) Measles, Mumps, Chicken Pox, Whooping Cough, Other _____	❑	❑
4.	Has your child had a history of earaches, sore throats or tonsilitis? _____	❑	❑
5.	Has your child been given oxygen, been under general anesthesia, or had any surgical procedures? _____	❑	❑
	If yes, when? _____		
6.	Has your child had any unfavorable reactions to any foods, medicines or drugs, including antibiotics and local anesthetics? _____	❑	❑
	if yes, please explain _____		
7.	Does your child have any special problems we should be aware of? _____	❑	❑
8.	Date of last dental care _____	❑	❑
9.	Has your child any history of thumb, finger, lip sucking or nail biting? _____	❑	❑
10.	Is your child currently *Breast* or *Bottle* fed? (if yes, circle one) _____	❑	❑
11.	Has your child had a history of missing teeth? _____	❑	❑
12.	How do you think your child will respond to the dentist? _____	❑	❑
13.	Has your child had any unfavorable experience in a medical or dental office? _____	❑	❑
	(if yes, please explain) _____		
14.	Is your child taking any medication? (if yes, what kind and reason for taking) _____	❑	❑
15.	What is your child interested in? (Pets, hobbies, etc.) _____		
16.	Please add anything you feel will help us in understanding and treating your child. _____		
17.	Reason for this visit? _____		
18.	Is your child in pain now? _____	❑	❑