

I. GENERAL INFORMATION:

1. Father's Name _____ SS # _____
 2. Mother's Name _____ SS # _____
 3. Home Address _____ 4. Home Phone _____
 Street _____
 City _____ State _____ Zip _____
 5. Father's Occupation _____ Father's Birthdate _____
 Employed by _____ Dental Insurance Co. _____
 Bus. Address _____ Group # _____
 Bus. Phone _____ Union Local # _____
 6. Mother's Occupation _____ Mother's Birthdate _____
 Employed by _____ Dental Insurance Co. _____
 Bus. Address _____ Group # _____
 Bus. Phone _____ Union Local # _____
 7. Child lives with: Father Mother Stepfather Stepmother Other _____ 8. Is your child adopted? Yes No
 9. Person responsible for account _____
 10. In case of emergency and parent unavailable, call: _____
 Name _____ Phone _____
 11. Who referred you to us? _____

II. CHILD'S HISTORY

Child's Name _____
 First _____ Middle _____ Last _____ Nickname _____

Age _____ Birthday _____ Sex: Boy Girl Child's physician: Dr. _____
 Month _____ Day _____ Year _____

- | | |
|--|---------------|
| | CIRCLE |
| 1. Has your child ever had heart trouble, bleeding disorder, epilepsy, brain injury, diabetes, asthma, kidney or liver disease?
(If yes, check any/ all that apply) | Yes No |
| 2. Any other medical, emotional or mental problems? Explain _____ | Yes No |
| 3. Does your child have any allergies? List _____ | Yes No |
| 4. Has your child ever been hospitalized? Explain _____ | Yes No |
| 5. Is your child taking any medicine now? List _____ | Yes No |
| 6. Does your child take vitamins with fluoride, fluoride drops or fluoride tablets? | Yes No |
| 7. Does your child have a finger, thumb, pacifier or other sucking habit now? | Yes No |
| 8. Is there any history of mouth injuries? When and how _____ | Yes No |
| 9. Child's previous dentist: Dr. _____ Date of last dental visit _____ | |
| 10. For children age 5 and under only: if child was bottle fed, until what age? _____ What was in the bottle? _____ | |
| 11. Reason for this visit: Check-up and Cleaning <input type="checkbox"/> Emergency Care only <input type="checkbox"/> Orthodontics <input type="checkbox"/> Other _____ | |

Remarks _____

III. PERMIT FOR DENTAL SERVICES UPON A MINOR

1. I, being the parent or guardian of (Child's Name) _____ do hereby authorize and request the performance of dental services upon the person of this patient; and authorize whatever procedures that the judgement of Dr. George Mednick or Dr. Jeff Alcaide may dictate during treatment. This may include the administration of local anesthetics or nitrous oxide as deemed necessary by Dr. George Mednick or Dr. Jeff Alcaide for the comfort and well-being of the child. I hereby authorize the release of records to and from other health professionals.
2. Your child's first visit will include an oral examination, x-ray diagnosis (when deemed necessary), cleaning and fluoride treatment. You will then be informed of all services and given a cost estimate before any further treatment is rendered for your child. A written description of our procedures is available upon request.

 Date _____ Signed _____ Relationship to patient _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE CHARGES SHOWN ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION. I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

 SIGNED (INSURED PERSON)