Employer __

Plan Name___ Address ___

Group # ___

Mother's/Guardian's Name	
Address (if different from patient's) _	
	-
Home Phone ()(if different from above)	Work Phone ()
(if different from above)	(if different from above)
E-mail	
Employer	
Soc. Sec. #	Birthdate
Do you have dental insurance covera	age for minor/child? Yes No
Plan Name	Phone ()
Address	
Group #	Policy #
No Child's Medical Assistance I.D. #_	

Date of last visit to a dentist __ YES NO

Is your child eligible for treatment under Medical Assistance?

Yes

Has child complained about dental problems? Does child brush teeth daily?.....

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No _____ Phone (____) ___

Policy #_

Does child use floss every day?-----

Soc. Sec. # _____ Birthdate ___

Is fluoride taken in any form?..... Any injuries to mouth, teeth, head?

Any unhappy dental experiences?

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?

For what service?____

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YES

NO

Minor/Child's Physician		City/S	State		. 1110110 ()
Date of last physical examin	nation	Resu	ults		
ls Minor/Child under care of	f physician now?	YES NO	Medications	3	198
Receiving any medication o	or drugs?				
Ever been hospitalized?	***************************************	🗆 🗆			
Ever had surgery?		🗆 🗆	Allergies		
Is there excessive bleeding	when cut?				
Has minor/child had any his	story of or difficulty with any of	the following? If v	es, please ch	eck (✔).	
☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy		☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting		☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Pi	roblems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Prot	blems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis		☐ Mumps	☐ Other
n the event of an emergence	cy, whom should we contact?				
			L.		Dhana (
Name		Relat	tionship		Phone ()
Name		Relat	tionship		Phone ()
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