IN ORDER TO KEEP OUR RECORDS ACCURATE AND UP TO DATE PLEASE FILL OUT THE FOLLOWING. YOUR COOPERATION IS APPRECIATED.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_ CHILD’S FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_AGE: \_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_ZIP: \_\_\_\_\_\_\_\_\_\_

HOME #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOM CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAD CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL FOR APPOINTMENT REMINDERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WOULD YOU LIKE TO RECEIVE TEXT MESSAGES? PLEASE CIRCLE ONE, YES (RECEIVE TEXT MESSAGES) NO (DO NOT RECEIVE TEXT MESSAGES)

**\* IF YOUR INSURANCE INFORMATION HAS NOT CHANGED, PLEASE PROCEED TO 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
* Anemia
* Artificial heart valve
* Artificial joints
* Asthma
* Autism/ PDD/ Asperger’s
* Cancer
* Cerebral Palsy
* Chicken Pox
* Complications from sedation, general anesthesia, or anesthetic solutions
* Congenital Heart Disease
* Diabetes
* Down’s 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
* Lung/ Breathing Problems
* 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 that the child is allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications your child is taking currently and the reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discuss any medical/ dental problems or concerns your child has: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child seeing an orthodontist? \_\_\_\_\_\_\_\_\_\_\_\_ If Yes, what is the name of the orthodontist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child is here today for a 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR THE SAFETY OF YOUR CHILD WE ARE REQUIRED TO HAVE A PARENT/ GUARDIAN ON OUR PREMISES AT ALL TIMES.**

**PLEASE DO NOT LEAVE OUR PREMISES WHILE WE ARE TREATING YOUR CHILD.**