

Patient's name _____ Date Of Birth _____

Mother's name _____ Date of Birth _____

Mother's address _____ Zip _____ Phone _____

Mother's employer _____ SSN _____ Business phone _____

Father's name _____ Date of Birth _____

Father's address _____ Zip _____ Phone _____

Father's employer _____ SSN _____ Business phone _____

Does patient live with mother, father or both? _____ Who is responsible for this acct? _____

Does patient have insurance? _____ Name of subscriber _____

Name of insurance _____ Group number _____

Address _____ Telephone number _____

I hereby authorize payment directly to the above dentist for the surgical and/or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

SIGNATURE _____

Who referred patient to our office? _____

Name of nearest relative not living with you _____ Phone _____

Address _____

Reason for patient's visit _____ Date of last dental exam _____

Does patient have any drug allergies? _____ If yes, what _____

Is patient taking any medications? _____ If yes, what _____

Has patient ever had: Heart trouble _____ Bleeding problems _____ Rheumatic Fever _____

Heart murmur _____ Hepatitis, jaundice or liver disease _____ Fainting spells or seizures _____

Asthma or respiratory problems _____ Are there any health conditions we need to be aware of? _____

Explain _____

Does patient have or has he/she been exposed to AIDS or HIV VIRUS? _____

Patient's physician is _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of that patient whose name appears on this form to administer treatment deemed necessary or advisable in the diagnosis and treatment of this patient.

SIGNATURE _____ Relationship to patient _____

Date: _____