

Thank you for filling out BOTH sides of this form completely. This will enable us to help you more effectively. If you have any questions, please do not hesitate to ask for help.

Child's name: _____

Birthdate: _____ Age: _____ Sex: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Child's Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Who is accompanying the child today?

Name: _____ Relation to child: _____

Do you have legal custody of this child? _____

Is the child adopted? _____ Is the child in a foster home? _____

Other siblings seen in this office: _____

Previous/Present Dentist: _____ Date of last visit: _____

Parent's Marital Status: ___single ___married ___widowed ___divorced ___separated

Whom may we thank for referring you to our office?

Parent's Information:

Mother's Name: _____ Birthdate: _____

Mother's Address: _____

Social Security #: _____ Stepmother: _____ Guardian: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Email Address: _____

Employer: _____ Position: _____

Father's Name: _____ Birthdate: _____

Father's Address: _____

Social Security #: _____ Stepfather: _____ Guardian: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Email Address: _____

Employer: _____ Position: _____

Person Responsible for Account:

Name: _____ Relation to child: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Position: _____

Social Security #: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Relation to Child: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Primary Dental Insurance:

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____ Plan, Local or Policy #: _____
Policy Owner's Name: _____
Policy Owner's Address: _____
Relationship to Patient: _____ Social Security #: _____
Policy Owner's Birthdate: _____ Employer: _____
Employer's Address: _____
Orthodontic Coverage? _____ Yes _____ No

Secondary Dental Insurance:

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group #: _____ Plan, Local or Policy #: _____
Policy Owner's Name: _____
Policy Owner's Address: _____
Relationship to Patient: _____ Social Security #: _____
Policy Owner's Birthdate: _____ Employer: _____
Employer's Address: _____
Orthodontic Coverage? _____ Yes _____ No

Medical Card:

Medical Card Plan: _____
Medical Card #: _____

I hereby authorize the release of any information necessary to process my insurance claim. I also authorize my insurance benefits to be paid directly to Noonan, Brockman and Pollock D.D.S., Inc. and I understand that I am financially responsible for non-covered services.

A copy of this signature is as valid as the original.

Sign: _____ Date: _____

PATIENT'S NAME _____
Last First Initial Nickname Sex Date of Birth

PARENT'S/GUARDIAN'S NAME _____

MEDICAL HISTORY -CIRCLE THE APPROPRIATE ANSWER

COMMENTS

- 1. Is your child now under medical care? YES NO
- 2. Name of physician _____ Phone # _____
- 3. Date of last physical exam: _____
- 4. Does your child have a health problem? YES NO
- 5. Is your child taking any medication? YES NO
- 6. Was your child a patient in a hospital? YES NO
- 7. Does your child have a heart murmur? YES NO
- 8. Has your child had any serious illness? YES NO
- 9. Has your child ever had surgery? YES NO
- 10. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
- 11. Does your child have other allergies? YES NO
- 12. Does your child experience severe or prolonged bleeding? YES NO
- 13. Does your child have AIDS or has he/she tested HIV positive? YES NO
- 14. Has your child tested positive for hepatitis? YES NO
- 15. Does your child have any nervous disorders? YES NO
 Fainting? Seizures? Dizziness? Behavioral Problems?
- 16. Has your child had a history of: (circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental or physical disability, eyesight problems, cancer, infections, speech impairments, hearing loss, psychiatric treatment, sickle cell disease, cleft lip/palate.

DENTAL HISTORY

- 1. Is this your child's first dental visit? YES NO
- 2. If not, how long since the last visit? _____
- 3. Has your child had any problem with dental treatment in the past? YES NO
- 4. Has your child ever received a local anesthetic? YES NO
- 5. Have there been any injuries to your child's teeth or mouth? YES NO
- 6. Does your child have any toothaches? YES NO
- 7. When does your child brush his/her teeth?
 Upon arising After meals Before bed

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MED. ALERT