Dentistry for Children
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Orthodontics
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CHILD'S FULL NAME			PREFERRED NAME	
BIRTHDATE	AGE		WEIGHT	SEX
STREET	CITY		STATE	ZIP
SCHOOL	DISTRICT			GRADE
NAME(S) AND AGE(S) OF SIBLING(S)				
FAVORITE PLAYMATE, PET, TOY, HOBBY, OR SPORT				

HOW, OR FROM WHOM, DID YOU HEAR ABOUT OUR PRACTICE?

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? IF NOT, PLEASE SHARE WHY YOU WOULD LIKE TO MAKE A CHANGE	YES NO
DATE OF LAST VISIT	DENTIST
HOW WOULD YOU DESCRIBE YOUR CHILD'S PREVIOUS MEDICAL OR DENTAL EXPERIENCES?	
PLEASE DISCUSS YOUR EXPECTATIONS AND DESIRES REGARDING YOUR CHILD'S DENTAL CARE	

DOES YOUR CHILD HAVE REGULAR MEDICAL EXAMINATIONS?	YES NO	
PHYSICIAN		DATE OF LAST EXAM
ADDRESS		PHONE #
IS YOUR CHILD TAKING ANY MEDICATION(S)?	YES NO	IF SO, PLEASE EXPLAIN
HAS YOUR CHILD EXPERIENCED UNFAVORABLE REACTION TO ANY MEDICATION(S)?	YES NO	IF SO, PLEASE EXPLAIN
IS YOUR CHILD ADOPTED?	YES NO	IF SO, FROM WHERE?

PLEASE INDICATE ANY CONDITION(S) YOUR CHILD HAS/HAS HAD

____ CHICKEN POX	____ CONVULSIONS	____ RHEMATIC FEVER	____ CEREBRAL PALSY	____ SMALL POX
____ EPILEPSY	____ MEASLES	____ HEART CONDITION	____ KIDNEY DISEASE	____ ANEMIA
____ NERVOUSNESS	____ ASTHMA	____ BLOOD DISORDER	____ TUMORS	____ OTHER:
____ DIABETES	____ MUMPS	____ EMOTIONAL PROBLEMS		

PLEASE NOTE ANY SPECIAL INFORMATION ABOUT YOUR CHILD:

PARENT #1 NAME	PREFERRED NAME
HOME ADDRESS (IF DIFFERENT FROM CHILD'S)	BIRTHDATE
	SEX
HOME PHONE/CELL	WORK	EMAIL
OCCUPATION	EMPLOYER
SOCIAL SECURITY #	DRIVER'S LICENSE #

PARENT #2 NAME	PREFERRED NAME
HOME ADDRESS (IF DIFFERENT FROM CHILD'S)	BIRTHDATE
	SEX
HOME PHONE/CELL	WORK	EMAIL
OCCUPATION	EMPLOYER
SOCIAL SECURITY #	DRIVER'S LICENSE #

CHILD'S PARENTS ARE	MARRIED	DIVORCED	SEPARATED	NOT MARRIED
IF PARENTS DO NOT LIVE TOGETHER, WITH WHOM DOES THE CHILD LIVE?				
EMERGENCY CONTACT				
RELATIONSHIP	PHONE			

IT IS OUR POLICY TO INFORM YOU THAT PAYMENT OF FEES FOR PROFESSIONAL SERVICES IS EXPECTED AT THE TIME OF TREATMENT BY THE PARENT OR GUARDIAN IN ATTENDANCE. WE ACCEPT PAYMENT BY CHECK OR CASH. FOR THOSE WISHING THE CONVENIENCE OF EXTENDED PAYMENT PLANS, WE ALSO ACCEPT PAYMENT BY MASTERCARD, VISA, NOVUS/DISCOVER, AND AMERICAN EXPRESS.

BECAUSE THIS CHILD IS A MINOR, IT BECOMES NECESSARY THAT PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL TREATMENT IS BEGUN. AUTHORIZATION IS HEREBY GRANTED AS SUCH.

PERMISSION IS HEREBY GRANTED TO DR. KOGUT, DR. VILLASEÑOR, DR. GLENN, AND ASSOCIATES TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS REGARDING MY CHILD'S TREATMENT. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEES FOR PROFESSIONAL SERVICES RENDERED ON BEHALF OF THIS CHILD.

SIGNATURE ______________________________ DATE ____________________

RELATIONSHIP TO CHILD ______________________________