CHILD'S NAME _____ (Last) _____ (First) Date of Birth _____ Age _____ Sex _____

Father's Name _____ (Last) _____ (First) Father's Home Phone _____

Father's Occupation _____ Father Employed By _____ Business Phone _____

Mother's Name _____ (Last) _____ (First) Mother's Home Phone _____

Mother's Occupation _____ Mother Employed By _____ Business Phone _____

Person Who Shall Be Responsible For This Account _____ (Last) _____ (First) _____ (Relationship to Child)

Address _____ Town _____ Zip _____

Do You Have Dental Insurance? ☐ Yes ☐ No Whom May We Thank For Referring You To Our Office? _____

Child's Physician: Doctor _____ Address _____ Town _____

MEDICAL	YES	NO
IS YOUR CHILD. . .Allergic To ANY medicines?	☐	☐
Under medical treatment at this time?	☐	☐
Taking ANY medicines at this time?	☐	☐
Either physically handicapped or mentally retarded?	☐	☐
DOES YOUR CHILD. . . Have a heart problem?	☐	☐
Bleed excessvely when cut?	☐	☐
Have ANY other medical problems?	☐	☐
HAS YOUR CHILD. . . Had Rheumatic Fever?	☐	☐
Ever had surgery?	☐	☐
Ever been hospitalized?	☐	☐
Has your child's physician ever cautioned you as to some aspect of your child's health?	☐	☐

DENTAL	YES	NO
HAS YOUR CHILD. . . Ever been to the Dentist?	☐	☐
Had a bad experience at the Dentist?	☐	☐
Complained of dental pain recently?	☐	☐
Stopped sucking habits (thumb, pacifier, etc.)?	☐	☐
Stopped using a baby-bottle?	☐	☐
Are you concerned about any special dental problems of your child?	☐	☐

How would you describe your child's present dental condition? _____

Please list ANY questions you would like to have answered: _____

Approval for Treatment & Questionnaire Completed by: _____ (Signature)

Relationship to child: _____

PLEASE NOTE THAT PAYMENT IS REQUESTED WHEN SERVICES ARE RENDERED.