MEADOWS DENTAL GROUP

PATIENT INFORMATION-CHILD

Child's Name:____Date:________________________________

DOB (DD/MM/YY):____

Home address:____

Home Phone:____Cell:_____________________________________

Mothers name:______________________________Work#:______________________Cell:___________________

Fathers name:______________________________Work#:______________________Cell:___________________

School attended:____

Is this your child's first visit to a dental office?____

If not, when was your child's last dental visit?____

What was done for your child at that time?____

Has your child had any recent dental X-rays?____

Any previous problems at a dental office?____

Is your child having any dental problems at the present time?_______________________________

Name of person or office, if any, that referred you?____

Who is responsible for payment of this account?____

Do you, your spouse, or both have dental insurance?____

If yes, please fill in the following section completely.

INSURANCE INFORMATION

Primary Coverage

Name of insured:____

Is insured person a patient here?________________________________Insured's DOB:___________________________

Insurance plane name:____

Group#:_____________________________ID#:__________________________%covered:________________________

Insured's employer's name:____phone#:_________________________

Patient's relationship to insured Self? Spouse? Child? Other?

Secondary Coverage

Name of insured:____

Is insured person a patient here?________________________________Insured's DOB:___________________________

Insurance plane name:____

Group#:_____________________________ID#:__________________________%covered:________________________

Insured's employer's name:____phone#:_________________________

Patient's relationship to insured Self? Spouse? Child? Other?

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MEDICAL HISTORY

Child's medical doctor:____________________________________Phone# or city:____

Is your child under a Physicians care for any problems?:____

Name of any medications taken by your child:____

Does your child have now or in the past (please check off those that apply):

____Heart problems

____Blood disorders

____Diabetes

____Autism/Aspergers

____Special needs

____Fainting/Seizures/Epilepsy

____Asthma

____ Liver or kidney disorder

____ADHD

Serious illness or hospitalization (past or present):____

Drug allergies (circle): Penicillin Codeine Anaesthetics

Others not listed:____

Allergies (general):____

Any condition or problem not listed above:____

Is there anything else we should know about your child to help us treat him/her?

____

____

To the best of my knowledge, this information is complete and correct. If my child ever has a change in his/her health, I will inform the doctors at the next dental appointment.

Parent/Guardian's signature____ **Today's date**_________________________