PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date						
Patient's name						
Last Address		rst	Middle			
AddressStreet Nickname	Birthdate So	City	Zip			
School_						
Parent or guardian name						
Whom may we thank for referring yo	ou to our office?					
	RESPONSIBLE PARTY I	NFORMATION				
Name						
Last Residence	Fil	rst	Middle			
ResidenceStreet		City	Zip			
Mailing AddressStreet		City	Zip			
	Home phone Work phone Email address					
•						
Previous Address (If less than 3 years Social Security #						
-		•	Relationship to Patient No. years employed			
Spouse's Name	•	•	•			
		•	No. years employed			
Social Security #	Birthdate _	BirthdateWork Phone				
	DENTAL INSURANCE IN	NFORMATION				
Insured's Name	Insured's Social Security #					
Insurance Company	Group No	Group No Local No				
Insurance Co. Address		Phone No				
Do you have dual coverage? Yes_	No If yes:					
Insured's Name Insured's Social Security #						
		Local No.				
Insurance Co. Address	urance Co. Address Phone No					
	EMERGENCY INFO	RMATION				
Name of nearest relative not living v	vith you					
Complete address						
Sileet		City	Zip			
Phone						
I understand that, where appropriate	e, credit bureau reports may be ob	otained.				
Parent Signature						
Updates (date & initial)						

MEDICAL HISTORY

Address Phone Please circle Yes or No (If Yes, please fill in details) Yes No Is the patient taking any medication? Yes No Is the patient taking any medication? Yes No Is the patient allergic to any medication? Yes No History of a major illness? Yes No Has the patient had any operations? Yes No Has the patient had any operations? Yes No Has the patient had any operations? Yes No Has meanstruation started? Yes No Has menstruation started? Yes No Is the patient pregnant? Circle any of the medical conditions below that the patient has had or currently has. Abnormal bleeding/Hemophila Diabetes Hepatitist_liver problems Anormia Diaziness Herpes Anthritis Herpes Anthritis Herpes Anthritis Herpes High Blood Pressure Prolonged Bleeding Radiation/Chemotherapy Radiation/Chemotherapy High Blood Pressure Prolonged Bleeding Radiation/Chemotherapy Radiation/Chemotherapy High Blood Pressure High Blood Pres	Physician								
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