FRISCO DENTAL ASSOCIATES

Thank you for taking the time to provide us with the following information !

PLEASE PRINT

I. PATIENT INFORMATION

A. Child's Name ______________________ M ______ F ______

Nickname ______________ Date of Birth ______________ Age ______________

Address ____
Street City State Zip

Home Phone ______________ School ______________ Grade ______

Physician Name ______________________ Phone ______________

Address ____
Street City State Zip

Former Dentist Name ______________________ Phone ______________

Names and ages of other children in family ______________________

____

____

Nearest relative NOT living with child: Name ______________________

Home Address ______________________ Home Phone ______________

Relationship with Child ______________________ Work Phone ______________

II. PARENT/GUARDIAN INFORMATION

A. Father's Name ______________________ S.S.# ____-____-____ D.O.B. ____________

Home Address if different ____
Street City State Zip

Home Phone ______________ Work Phone ______________ Cell Phone: ______________

Employed by ______________ Occupation ______________ Email: ______________

Dental Insurance Company ______________________ Group No. ______________

Address ______________________ Phone ______________

B. Mother's Name ______________________ S.S.# ____-____-____ D.O.B. ____________

Home Address if different ____
Street City State Zip

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Employed by ______________ Occupation ______________ Email: ______________

Dental Insurance Company ______________________ Group No. ______________

Address ______________________ Phone ______________

C. Legal Guardian's Name ______________________ S.S.# ____-____-____ D.O.B. ____________

Home Address ____
Street City State Zip

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Employed by ______________ Occupation ______________ Email: ______________

D. Person or agency Responsible for child's account, if other than parent: Name ______________________

Address ____

Phone ______________________ Relationship to child ______________________

Whom may we thank for referring you to our office ? ______________________

- OVER -

III. Health History

A. Is your child taking any medication or drugs? .... YES NO
Please list ____________________

B.. Is your child sensitive or allergic to any medication or drugs ? .... YES NO
Please explain ____________________

C. Is your child under medical care at present? .... YES NO
Please explain ____________________

D. Has your child any history of being under general anesthesia or oxygen ? .... YES NO
Please explain ____________________

E. Has your child ever had a bad experience with previous medical or dental care .... YES NO

F. Has your child any of the following ? Please Circle **YES** or **NO** to each item.

Condition			Condition			Condition		
Heart Condition	YES	NO	Ulcers	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease	YES	NO	Bowel Problems	YES	NO	Hepatitis B Serum	YES	NO
Rheumatic Fever	YES	NO	Developmentally Disabled	YES	NO	Hepatitis C	YES	NO
Mitral Valve Prolapse	YES	NO	Epilepsy or Seizures	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Fainting or Dizzy spells	YES	NO	H.I.V. Positive	YES	NO
Heart Pacemaker	YES	NO	Brain Injury	YES	NO	Liver Disease	YES	NO
High Blood Pressure	YES	NO	Hyperactivity	YES	NO	Blood Transfusion	YES	NO
Diabetes	YES	NO	Nervousness	YES	NO	Hemophilia	YES	NO
Hypoglycemia	YES	NO	Sinus Problems	YES	NO	Anemia	YES	NO
Thyroid Problems	YES	NO	Allergies or hives	YES	NO	Sickle Cell Disease	YES	NO
Arthritis	YES	NO	Asthma	YES	NO	Kidney Problems	YES	NO
Rheumatism	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Cancer	YES	NO	Emphysema	YES	NO	Sore Throats	YES	NO
Chemotherapy	YES	NO	Tuberculosis	YES	NO	Tonsillitis	YES	NO
Radiation Therapy	YES	NO	Chronic Cough	YES	NO	Ear Aches	YES	NO
						Hearing loss	YES	NO

Please explain any of the above in detail ____________________

____

____

G. Does your child need to be premedicated prior to dental treatment? YES NO

H. Please describe any dental problems or special concerns ____________________

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I. Please list the names and phone numbers of family members or other people authorized by you to seek dental care, schedule appointments and make decisions regarding your child.

Name ____________________ Relationship to child ____________ Phone ____________

Name ____________________ Relationship to child ____________ Phone ____________

Name ____________________ Relationship to child ____________ Phone ____________

IV. CONSENT:

I authorize the staff of **Frisco Dental Associates** to take x-rays, study models, photographs, or other diagnostic aids deemed appropri-ate to make a thorough diagnosis of the patient's dental need. I also authorize the staff to perform all mutually agreed upon treat-ment and to use those methods deemed appropriate in completing that treatment. I understand that I am financially responsible for payment of dental services at the time those services are render, unless other arrangements have been made in advance.

Patient ____________________ Date ____________________

By: ____________________ Relationship to Patient ____________________

THANK YOU ! We know it is a long form. This information is necessary to provide the BEST DENTAL CARE we can for your child.