PERSONAL INFORMATION OF ______________________ Date ________

This personal information will help us to give the most consideration of your time and feelings.
It is important to have complete answers. All information is, of course, confidential.

Are you aware of your child having any particular dental problems? ______________________

Is your child having any discomfort or pain? ______________________

Is this your child's first visit to a dental office? ________ If not, how long since the last examination? ________

What was done for your child at that time? ______________________

Has your child ever had any serious illnesses, such as rheumatic fever, any kind of heart problem or heart murmur, diabetes, etc?
Yes ____; No ____ If yes, what? ______________________

Is your child sensitive or allergic to any food or medication? ____ If so, what? ______________________

Who is your child's physician? ______________ Address: ______________

The date of your child's last medical check-up: ________ Is your child under any treatment at present? Yes ___ No ___

If so, for what? ______________ What medication does your child take? ______________

Is the child's dental work covered by any insurance? ______ If yes, name of insurance company ______________

Name of policy holder ______________ Social Security No. ______________

May we ask who recommended this office? ______________________

Child's name: ______________ Date and year of birth: ______________

Home address: ______________ City: ______________ Zip: ________

Home phone: ______________ School ______________ Grade ________

Mother's name: ______________ Occupation: ______________

Where does she work? ______________ Phone: ______________ Ext.: ________

Father's name: ______________ Occupation: ______________

Where does he work? ______________ Phone: ______________ Ext.: ________

Responsible person: ______________________

Date: ________ Parent's Signature: ______________________ Thank you.

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