

WELCOME TO OUR OFFICE!

Thank you for trusting us with your dental care! We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name		Home Phone		Cellph	one				
		Age Sex_		Marita	- •				
Address Apt # Cit						Zip			
Employer				Work F	Phone				
Spouse's Name				Spous	e's Employer				
Person to Notify in Case	e of Emergency			Phone					
Relative or Friend not L	iving with You		Phone						
Student:									
	Family Mer					t to the Dentist			
Spouse									
Child	Ble At Devictory 19 x 120 2								
Child									
Child									
RESPONSIBLE PARTY'S	INFORMATION		'			<u> </u>			
Person Responsible Fo	r Account								
Relationship To Patient	Relationship To Patient			Home Phone Work Pho					
Mailing Address			City		State	Zip			
SS #			Driver License #						
Employer		+ 00	Occupation	~					
Employer's Address		r. De	City	<u> </u>	State	Zip			
Dental Insurance	Yes 🗌 No	FOD	Secondary Insurance		□ No				
Insured's Name		IUK	Insured's Name						
Relationship To Patient			Relationship To Patien	t					
SS # DOB			SS #DOB						
Employer			Employer						
Ins. Co. Or Plan			Ins. Co. Or Plan						
Union/Grp. Name			Union/Grp. Name						
Grp. or Policy #			Grp. or Policy #						
Date of Employment			Date of Employment _						
For your convenience,	we offer the following meth	ods of payment. Pl	ease check the option	you prefer. P	ayment in ful	Il at each appointment.			
☐ Cash ☐ VISA	☐ Mastercard ☐ C	areCredit 🗌 Gr	reenSky						
How did you hear abou	t this office? Friends/Fam	ily □ Flyer □ G	oogle 🗌 Yelp 🔲 F	acebook 🛚	Instagram	□Other			
Why are you here today	? Routine Check-up	Toothache	aces 🔲 Improve Sm	ile 🗌 Other	r				
CONSENT TO FINANCIA	L RESPONSIBILITY								
anesthetic as may be deemed ac	igned, consent to the performing of what hisable by the dentist. I have also been en the above named insurance carrier for puriting.	explained the consequences	of partial and/or no treatment.	I hereby authorize n	ny dentist to releas	e any and all medical information			
remaining balance. I understand a performed if my insurance/dental	carrier to pay directly to the within names some dental services I receive may requir plan has a yearly deductible, I understar per annual) will be charged on the unpaid	re a co-payment from me. T nd it must be satisfied before	The amount of the co-payment was treatments begins. I also under	vill vary according to erstand co-payment	the insurance/der must be paid in fu	ntal plan I have and the procedure that is			
I further understand dental service	es not covered by my insurance/dental p	olan may be prescribed in ce	ertain cases by the attending der	ntist. Usual, custom	ary and reasonable	e fees will be charged for such services.			
I also understand there will be a d	charge for any missed appointment which	n is no canceled within 24 h	ours in advance.			22+			
Patient/Guardian Signat	ure	Date _	73 .						

Date _____

A+ Dentistry

FOR KIDS

Guardian Signature _
© A+ Dentistry for Kids



	Blood Pressure	Date	Insurance	
Year 1				
Year 2			Name	Date of Birth
Year 3				

Fig. 1.6.	These questions are for your benefit and assure that treatment will take into consideration your past and present health status. So concern, but they are all associated with proper oral health care. Please answer each question and make YES or NO as appropria		estions may seem un	related	d to yo	our dental	
2. Are you rote under the care of a physician?	Medical History					YES	NO
Physician name from it is address Security Securi	1. Are you in good health?						
S. How you over back any serious likes or operation? 4. Have you over back any serious likes or operation? 4. Have you over back you shark was the proclean? 4. Have you over back hospitalized? 4. Have you over back hospitalized? 4. Sex you taking medicine? Or any drough? Penicillis Tetracycline What desage? 5. Any you stainly a calledgin or any drough? Penicillis Tetracycline Sulfis Drough Angrins Coodine What desage? 6. Any you stainly an calledgin or any drough? Penicillis Tetracycline Sulfis Drough Angrins Coodine What desage? 7. Obyou have, on have you had any of the following: 7. Obyou have, on have you had any of the following: 8. Hapt Murmurs Angrins Angrins Sulfis Drough Angrins Coodine What Murmurs Wissins What Murmurs Wissins What Murmurs What Murmu							
If so, what was the problem? If so,	If so, what is the condition being treated?						
4. Nave you seem been hospitalized 27 5. Also you seem been hospitalized 27 6. Are you seem been hospitalized 27 6. Are you seemalithe or allergic to any drugs? Perilcillin Tetracycline, etc) Perilcillin Perilcillin Tetracycline, etc) Perilcillin Perilcil	Physician name/ phone # / address						
See Note was the problem?	3. Have you ever had any serious illness or operation?						
S. Ase you sharing medicine? Or any recreational drugs (ecitatey, cocaine, etc) 6. Are you sharing redicine? Or any recreational drugs (ecitatey, cocaine, etc) 7. Do you have, or have you shard any of the following: 7. Do you have, or have you had any of the following: 7. Do you have any power had any of the following: 7. Do you have any power had any of the following: 7. Do you have any power had any of the following: 7. Do you have any power had any of the following: 7. Do you have any power had a you are trained in the power had been an undersorable reaction from a local anesthete(?) 8. Do you have any problems associated with your menstrual period? 9. In you sever had a local anesthete(?) 10. Alway you currently taking, or have you ever taken the drug Phan-Phen? 11. (Women) by you take a possibility you may be pregnant? 12. (Have you over had a local anesthete(?) 13. Have you over had a local anesthete(?) 14. Have you over had a local anesthete(?) 15. Have you over had a local anesthete(?) 16. Have you over had a local anesthete(?) 17. Have you over had a local anesthete(?) 18. Have you over had a local anesthete(?) 19. Have you over had a local anesthete(?) 10. Have you over had a local anesthete(?) 10. Have you over had a local anesthete(?) 11. Have you over had a local anesthete(?) 12. Have you over had a local anesthete(?) 13. How you fain ment lead the testing of an accident? Yes No When 14. How long since you that a full mouth X-mys? 15. Have you over had a local anesthete(?) 16. Is any currently taking, or have you ever taken the drug Phan-Phen? Have you over had a local anesthete(?) 17. Have you over had a local anesthete(?) 18. Have you over had a local anesthete(?) 19. Have you over had a local anesthete(?) 19. Have you over had a local anesthete(?) 10. Have you over had a local anesthete(?) 10. Lowers given by the following answers are true and covered the local power local field by the fower local power local field by the following answers are true and	If so, what illness or operation?					_	
See	4. Have you ever been hospitalized?						
8. An you sensitive or allergic to any drugs? Penicillin Tetracycline Sulfa Drugs Aspirin Codeline	If so, what was the problem?					_	
Content to their, what druging? Peniculian Tetracycline Sulfa Drugs Aspirin Codeline Peniculian Tetracycline Peniculian Tetracycline Peniculian Tetracycline Peniculian Penicu	5. Are you taking medicine? Or any recreational drugs (ecstasy, cocaine, etc)						
7. Do you have, or have you had any of the following: Yes No	If so, What? What dosage?					_	
7. Do you have, or have you had any of the following: Yes No	6. Are you sensitive or allergic to any drugs?	Э					
Yes No	Other: If other, what drug(s)?					=	
Heart Murmur Joint Replacement Replacement Replacement Replacement Reart Altrack Ulcers Reaction Therapy Cotros Medicine Hepatitis or Joundice Glaucoma Blood Diseases Returnatic Fever Reaction Therapy Cotros Medicine Hepatitis or Joundice Glaucoma Blood Diseases Returnatic Fever Reaction Therapy Cotros Medicine Reaction Therapy Cotros Medicine Reaction Therapy	7. Do you have, or have you had any of the following:						
High Blood Pressure Allergies or Hives Heart Aliments or Attack Glaucoma Glauc	Yes No Yes No Yes No Yes	s No		Yes	No		
Radiation Therapy Cortisone Medicine Hepatitis or Jaundice Glaucoma Blood Disease Pheumatic Fever Excessive Bleeding Fainting Spells or Seizures Arthritis Drug Addiction Drug Addiction Cold Spares Hit/AIDS Hit/AIDS Hit/AIDS Hepatitis or Jaundice Path in Javy joints Venereal Disease (Syphilis, Gonorrhea) Emphysema Kidney Disease Hit/AIDS Head Injuries Hemophilia Hemoreal Disease Artificial Prosthesis Bruise Easily Asthma Hemophilia Hemoph	☐ ☐ Heart Murmur ☐ ☐ Joint Replacement ☐ ☐ Epilepsy or Seizures ☐		Anemia			Liver Dise	ease
Rheumatic Fever Excessive Bleeding Fainting Spells or Seizures Arthritis Dug Addiction Chemotherapy (Gancer, Euklemia) Emphysema Kidney Disease Arthritis Weinereal Disease (Syphilis, Gonorhea) Emphysema Kidney Disease Arthritis Weinereal Disease (Syphilis, Gonorhea) Emphysema Kidney Disease Arthritis	☐ ☐ High Blood Pressure ☐ ☐ Allergies or Hives ☐ ☐ Heart Ailments or Attack ☐		Ulcers			Sinus Tro	uble
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Thyroid Disease Mental Disorder Angina Pectoris Head Injuries Hemophilia Hemophilia Thyroid Disease Thyroid Disease Psychiatric Treatment Congenital Heart Lesions Diabetes Stroke Blood Transfusion Gerebral Palsy Heart Surgery (Valve Replacement) Prosthetic Joints YES NO No you have any disease, condition or problem not listed that you think we should know about? Fiso, what? Psychiatric Treatment YES NO No you smoke? If yes, how much per day? YES NO No you smoke? If yes, how much per day? YES NO No you smoke? If yes, how much per day? YES NO No you have any problems associated with your menstrual period? 11. (Women) Its there a possibility you may be pregnant? Potatal History No you have any problems associated with your menstrual period? 13. (Women) Do you take birth control pills? Potatal History No you have any problems associated with any previous dental treatment? No you have any serious trouble associated with any previous dental treatment? No you have any serious trouble associated with any previous dental treatment? No you have any serious trouble associated with any previous dental treatment? No you have any serious trouble associated with any previous dental treatment?	☐ ☐ Cardiac Pacemaker ☐ ☐ Path in Jaw joints ☐ ☐ Venereal Disease (Syphilis, Gonorrhea) ☐		Cold Sores			HIV/AIDS	;
Tumors and Growths Psychiatric Treatment Congenital Heart Lesions Diabetes Stroke Heart Surgery (Valve Replacement) Prosthetic Joints YES NO	☐ ☐ Nervous Disorders ☐ ☐ Respiratory Disease ☐ ☐ Artificial Prosthesis ☐		Bruise Easily			Asthma	
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