

Amarillo Pediatric Dentistry

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Child's Name _____
Child's S.S. No. (if known) _____ Sex ___ Age ___ Date of Birth _____
Home Phone _____ Home Address _____
Cell Phone _____ City _____ State _____ Zip _____
E-Mail Address _____
Father's Name _____ Marital Status S M W D Sep
Father's address & phone if different from above _____
Driver's License No. _____ Father's S.S. No. _____ Date of Birth _____
Father's Place of Business _____ Phone _____
Mother's Name _____ Marital Status S M W D Sep
Mother's address and phone if different from above _____
Driver's License No. _____ Mother's S.S. No. _____ Date of Birth _____
Mother's Place of Business _____ Phone _____
Legal Guardian (if different from parent) _____
Person Financially Responsible _____
Do you have Dental Insurance? _____ Do you have Medicaid (Title XIX) _____
Family Dentist _____ Child's Physician _____
Who can we thank for referring you to us? _____
Other children's names and ages _____
Have any family members been seen here before? Yes ___ No ___

Child's History

Date of child's last visit to dentist _____ For _____
Any injuries to mouth or teeth _____
Mouth habits – thumbsucking, nail biting, mouth breathing, etc. _____
Is child under care of physician now? ___ Is child taking any medications? _____
Has child ever been hospitalized? ___ Reason _____
Any allergies to drugs or medicines _____
Has child had any history with any of the following: ___ None
___ Anemia ___ Convulsions ___ Heart ___ Mononucleosis ___ HIV/AIDS
___ Allergies ___ Diabetes ___ Kidney ___ Malignancies ___ Pregnant
___ Asthma ___ Epilepsy ___ Liver ___ Retardation ___ Hearing
___ CP ___ Fainting ___ Measles ___ Thyroid ___ Mumps
___ Rheumatic Fever ___ Chronic Sinusitis
Any other dental or medical problem of special concern? _____

Permission to Treat

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of his services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient.

Photos and other dental records of my child may be used for teaching or instructional purposes.

Signature _____ Date _____ (OVER)

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