Chilld’s Name____

First Middle Last

Male______Female______Date of Birth______________Social Security# ________________________

Circle

Parent or Guardian (with which child resides)

Name____

Mailing Address_______________________________________

City____State_______________Zip________

Home phone___________________Work phone___________________Cell phone______________

Email _______________________________

Person responsible for this account if other than above

Name______________________________________Relationship to patient_____________________

Mailing Address_______________________________________

City____State_______________Zip________

Home phone___________________Work phone___________________Cell phone______________

Email _______________________________________

DENTAL INSURANCE INFORMATION

Name of policyholder____

Employer____

Insurance
Company____

Policyholder’s SS#____

Policyholder’s date of

Signature____Date____________________

Whom may we thank for referring you? ____

HISTORY

Is this the first visit to a dentist? YES NO

Previous Dentist Name? ____________________

Date of last visit? ____________________

Any X-rays? YES NO

Is this an emergency? YES NO

Are other family members patients here? YES NO

What, in your opinion, is the dental problem?____________________

Is there now or has there ever been any of the following: (Circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	

Is child under care of physician now? YES NO For what____________________

Allergic to any medication or allergic to anything else____________________

Taking any medicine (list)____________________

____

Has child had any history of: (Circle those that apply)

Anemia	Emotional Problem	Heart Trouble	Rheumatic Fever
Asthma	Epilepsy	Kidney Disease	Speech Impediment
Convulsions	Excessive Bleeding	Liver Disease	Tuberculosis
Diabetes	Hearing Problems	Mental Disturbance	Tumors

Others (Please List)____________________

Does child have any illness now? YES NO

If yes what?____________________

Any special problem not listed above?____________________

State child's interest and hobbies____________________

Name of physician____________________Phone____________________

Do you wish a copy of our examination sent to him? YES NO

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I acknowledge that I am responsible for informing the doctor about any changes in my child's health history prior to treatment. I understand that my child's health history information will be used as necessary for diagnosis or treatment by Dr. Sarah Frye.

SIGNATURE____________________Date____________________