AVONDALE DENTAL

CHILD REGISTRATION

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

PERSONAL INFORMATION

Child's Name _____ Nickname _____ Birth Date _____

Parent or guardian's name _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E mail address _____

Home Address _____ City _____ State _____ Zip_____

Billing Address _____ City _____ State _____ Zip _____

Drivers Lic. # _____ State _____ Social Security # _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency (not living with you) _____

Phone # _____ Relationship _____

CHILD'S HEALTH HISTORY

Physicians Name _____ Phone _____

Frequency of medicines during formation of permanent teeth? _____

History of serious illness _____

Mother's health during pregnancy? _____ History of Rheumatic fever? _____

Frequency of medicines during first 2 years of life? _____

Any medications taken regularly? (including vitamins, fluoride, etc.) _____

Any allergies? (drugs, food, latex, etc.)_____

Any medical problems or surgeries? _____

INSURANCE INFORMATION

PRIMARY Insurance Company _____ Group # _____

Name of Insured _____ SS or ID # _____ Birth Date _____

Relationship to Patient _____ Employer _____

SECONDARY Insurance Company _____ Group # _____

Name of Insured _____ SS or ID # _____ Birth Date _____

Relationship to Patient _____ Employer _____

I, the undersigned, authorize dental treatment to be rendered by the Dentist and his staff, and assume financial responsibility.

Parent/Guardian _____ Date_____