CHILD
CONFIDENTIAL PATIENT INFORMATION

PLAZA DENTAL CARE LLC

PERSONAL INFORMATION

Date_____

Child's Name:_____Preferred Name: _____Date of Birth_____

Parent's Name: _____

Address:_____
(If P.O. Box, please include street address) Street City State Zip

Telephone: _____ Parents Cell #_____

Father's Employer:_____ Business Telephone_____

Mother's Employer:_____ Business Telephone_____

Referred by:_____, we would like to thank them. ❑ Family ❑ Co-Worker
❑ Neighbor ❑ Insurance ❑ Phone Book ❑ Newspaper ❑ Welcome Wagon ❑ Other_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relationship:_____ S.S. #_____

Address:_____
Street City State Zip

Telephone: Home:_____ Business:_____ Cell:_____
I will be responsible for payment of the services furnished and agree to pay for such treatment regardless of insurance or any other third party involvement. I also agree, if the need arises for my account to be referred to collection, to pay all agency fees, court costs, attorney's and legal fees.

Signature _____ Date_____

In case of divorce, the parent who schedules the dental treatment is **responsible** for payment regardless of any court document.

Signature _____ Date_____

INSURANCE INFORMATION

Primary Insurance Co.:_____

Employee:_____ Relationship:_____ S.S. #_____

Employer:_____ Policy Number_____

Employee's Date of Birth:_____

Secondary Insurance Co.:_____

Employee:_____ Relationship:_____ S.S. #_____

Employer:_____ Policy Number_____

Employee's Date of Birth:_____

(over)

Update_____

HEALTH INFORMATION

Personal Physician_____M.D._____
Name Address

YES NO

____ ____ 1. Has your child been hospitalized within the past 2 years?
For what?_____

____ ____ 2. Is your child currently being treated by a physician?
For what?_____

____ ____ 3. Is your child taking any medication or drugs? What?_____
_____

____ ____ 4. Has your child experienced an unusual reaction or allergy to: ❑ anesthetic ❑ penicillin
❑ aspirin ❑ codeine ❑ other drug (please list) _____

____ ____ 5. Has your child ever been seriously ill?

____ ____ 6. Is your child allergic to any metals? What?_____

____ ____ 7. Has your child ever had a skin rash or other reaction to metal jewelry? To what?_____
_____

____ ____ 8. Does your child bleed excessively upon injury or bruise easily?

____ ____ 9. Is your child fearful of dental or medical treatment?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOUR CHILD HAS HAD:

A. AIDS	F. Heart Murmur	K. Lung Problems
B. Asthma	G. Heart Problems	L. Rheumatic Fever
C. Cancer	H. Hepatitis	M. Sinus Problems
D. Diabetes	I. Jaundice	N. Tuberculosis
E. Epilepsy	J. Kidney Problems	O. Other Diseases

***If you circled either G or O describe condition _____

_____

_____

_____ _____ _____
Signature Date Reviewed By

_____

_____

_____

_____

_____