



Parent or Guardian

Parent or Guardian Information - Person Responsible for the Account

The following is for:  Parent  Guardian

Name: \_\_\_\_\_

Male  Female  Married  Single  Other: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street, City, State, Zip \_\_\_\_\_

Second Parent or Guardian Information

The following is for:  Parent  Guardian

Name: \_\_\_\_\_

Male  Female  Married  Single  Other: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street, City, State, Zip \_\_\_\_\_

Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- AIDS
- Anemia
- Arthritis, Rheumatism
- Artificial Heart Valves
- Artificial Joints
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cortisone Treatments
- Cough, Persistent
- Cough up Blood
- Diabetes
- Epilepsy
- Fainting
- Glaucoma
- Headaches
- Heart Murmur
- Heart Problems
- Describe \_\_\_\_\_
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV Positive
- Jaw Pain
- Kidney Disease
- Liver Disease
- Mitral Valve Prolapse
- Nervous Problems
- Pacemaker
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Rheumatic Fever
- Scarlet Fever
- Shortness of Breath
- Skin Rash
- Stroke
- Swelling of Feet or Ankles
- Thyroid Problems
- Tobacco Habit
- Tonsillitis
- Tuberculosis
- Ulcer
- Venereal Disease

MEDICATIONS  
List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES  
Codeine Allergy  Yes  No  
Penicillin Allergy  Yes  No

Anesthetic Allergy  Yes  No  
Latex Allergy  Yes  No  
Other Allergies \_\_\_\_\_

Authorization

Please Initial

\_\_\_\_\_ I acknowledge I have received a copy of the HIPPA Policy

\_\_\_\_\_ I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_ I authorize the dentist to release all information necessary to secure the payment of benefits.

\_\_\_\_\_ I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_ I have received a copy of the financial policy.

\_\_\_\_\_ Payment is due in full unless prior arrangements have been approved.

Signature \_\_\_\_\_ Date \_\_\_\_\_