WELCOME TO OUR OFFICE

Specializing in Dentistry for Children and Adolescents

Ann Freedman, D.M.D. and Jacqueline Galvez, D.D.S.

Today's Date_____

Child's Name (Last)_____ (First)_____(M.I.)_____

Sex_____ Age_____ Date of Birth_____ Phone Number ( )_____Cell ( )_____

Address _____
Apt. # City State Zip

List all members of your household who are our patients_____

E-MAIL ADDRESS (Needed to Confirm Appointments)_____

Emergency Contact other than parent(s): Name_____ Phone:_____ Relation_____

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

Parent's Information

Must be filled out in full

Who will pay account _____ Relationship to patient _____

MOTHER: FULL NAME _____ FATHER: FULL NAME _____

Address (if diff. than child)_____ Address (if diff. than child)_____

City _____ State ____ Zip_____ City _____ State ____ Zip_____

Phone: Home( )_____**Cell ( )**_____ Phone: Home( )_____ **Cell ( )**_____

Mother's Social Security # _____ **Father's Social Security #** _____

Mother's Birthday _____ **Father's Birthday** _____

Mother's Driver's License #_____ **Father's Driver's License #**_____

MOTHER'S EMPLOYMENT **FATHER'S EMPLOYMENT**

Occupation _____ Occupation _____

Employer _____ Employer _____

Work Address_____ Work Address_____

City _____ State ____ Zip_____ City _____ State ____ Zip_____

Phone: Work ( )_____ Phone: Work ( )_____

Marital status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single Which parent has custody? _____

Dental Insurance Information

Primary

Name of insured:_____ Is insured a patient? [ ] Yes [ ] No
Last First MI

Insured's Birth Date_____ ID# _____ Group # _____

Insured's Employer Name and Address:_____

Patients relationship to insured: [ ] Self [ ] Child [ ] Other _____

Insurance Plan Name_____

Insurance Phone Number and Address: ( )_____

Secondary

Name of insured:_____ Is insured a patient? [ ] Yes [ ] No
Last First MI

Insured's Birth Date_____ ID# _____ Group # _____

Insured's Employer Name and Address:_____

Patients relationship to insured: [ ] Self [ ] Child [ ] Other _____

Insurance Plan Name _____

Insurance Phone Number and Address: ( )_____

PLEASE FILL OUT REVERSE SIDE →

Child's Dental Health Information

Purpose of this visit _____

Is this the child's first dental visit? [ ] Yes [ ] No

Is the child taking any fluoride by prescription (such as tablets or drops)? [ ] Yes [ ] No

Did the child sleep with a bottle? [ ] Yes [ ] No

Or fall asleep while nursing? [ ] Yes [ ] No

Does the child have any oral habits? [ ] Yes [ ] No

[ ] Thumb [ ] Pacifier [ ] Lip or nail biting [ ] Other _____

Has your child had a toothache lately? [ ] Yes [ ] No

Has your child had an injury to face or teeth? [ ] Yes [ ] No

To help us see growth patterns:

Have other members of the family had orthodontics (braces)? [ ] Yes [ ] No

Was the child adopted? [ ] Yes [ ] No Does the child know? [ ] Yes [ ] No

Please give date of last dental visit _____ Date of last x-rays _____Name of dentist_____

Was the experience favorable? [ ] Yes [ ] No If not please elaborate _____

How would rate your child's temperament? [ ] Anxious [ ] Average [ ] Calm

Are there any questions you would like the dentist to address? _____

Child's Medical Health Information

Name of Medical Physician:_____Phone # _____

Is the child taking any medication, **including birth control?** (Due to medication interactions) [ ] Yes [ ] No Please list:_____

_____

Has the child ever been hospitalized? [ ] Yes [ ] No Please explain_____

Please list any behavioral, developmental or emotional disorders, hearing loss, or other handicaps:_____

Has the child ever had any of the following? Please check those that apply:

☐ AIDS or HIV positive	☐ Blood/ Bleeding disorder	☐ Eye Disease	☐ Mental/Nervous disorder
☐ Allergies: Penicillin	☐ Cancer	☐ Glandular/Hormonal Disease	☐ Radiation/ Chemotherapy
☐ Allergies _____	☐ Cleft Lip or Palate	☐ Heart Disease/ Surgery	☐ Stomach problems/ Ulcers
☐ Anemia	☐ Diabetes	☐ Heart Murmur/ Rheum. Fever	☐ Tuberculosis
☐ Asthma/ Respiratory Dis.	☐ Ear Disease	☐ Hepatitis (Liver Disease)	☐ Tumors/ Growths
☐ Arthritis/ Joint Disease	☐ Epilepsy/ Seizures	☐ Kidney Disease	☐ Other _____

Agreement for Dental Services

1. The parent or legal guardian herby retains Dr. Ann Freedman and/or Jacqueline Galvez to render dental services to and for the benefit of the patient.
2. Since your child is a minor, it is necessary to obtain your permission before any necessary dental service can be rendered. Authorization is hereby granted. NO TREATMENT, X-RAYS OR ANESTHESIA WILL BE PERFORMED WITH OUT YOUR PRIOR KNOWLEDGE AND CONSENT.

_____ Date _____ Relationship to Child _____

Signature of parent, guardian, or patient (if of legal age)