

Patient Name _____ Likes to be called _____ Today's Date _____

Patient Address _____ City _____ State _____ Zip _____

Home Phone _____ Sex _____ Birthdate (Patient) _____

Patient SS# _____ Pediatrician _____ Phone # _____

Dental Insurance Company _____ Insured _____ Group No. _____

Address _____

Mother's Information Legal Custody: YES NO Father's Information Legal Custody: YES NO Parent's Information

Name _____ Name _____ Single _____

Employer _____ Employer _____ Married _____

Business Phone _____ Business Phone _____ Divorced _____

Cell Phone _____ Cell Phone _____ Spouse Deceased _____

Social Security _____ Social Security _____ Separated _____

Birthdate _____ Birthdate _____

Patient's weight _____ lbs _____ kgs Reason for dental visit _____

Has your child ever had any of the following? (Please check YES or NO by each item) If YES please explain below:

YES NO

		1. Heart Disease
		2. Rheumatic Fever
		3. Hepatitis or Liver Disease
		4. Diabetes
		5. Blood Transfusion
		6. Abnormal Bleeding
		7. Epilepsy/Seizures
		8. Tuberculosis
		9. Arthritis
		10. Kidney Disease
		11. Thyroid Disease
		12. Hormonal dysfunction
		13. Allergies to drugs or medications
		14. Hay Fever
		15. Asthma
		16. Tumor/Cancer
		17. Mumps/Measles/Chicken Pox
		18. Hospitalization
		19. GI Disease
		20. Pneumonia/Lung Disease
		21. Constant Ear Infections
		22. Anemia
		23. AIDS or AIDS related complex
		24. Other
Explain: Number, date, and duration _____		

	YES	NO
Is this your child's first visit?		
Has your child had any surgeries? Explain.		
Does your child have mental, physical or emotional special needs? Explain.		
Did your child have a baby bottle at nap and/or bed time? How long?		
Does your child have a finger or pacifier habit?		
Has your child had an unfavorable reaction to medical/dental treatment?		
Is your child taking any drugs or medicine now? What?		
Does your child have any other medical problem we should know about?		

Referral Information

Whom may we thank for referring you to our practice? Friend Patient Relative Postcard

Physician Dentist Yellow Pages Newspaper Other _____

Name of person referring you to our practice: _____

I, being the parent or legal guardian of the above named minor patient, hereby do authorize and request the performance of dental services for this patient by Dr. Robert A. Boraz. I understand that Dr. Robert A. Boraz and such assistants as he may designate to treat the above-mentioned patient will use procedures and patient management techniques that are reasonable, necessary and advisable and will be performing services including, but not limited to examination, x-rays, cleaning, fluoride, and use of a mouth prop (tooth pillow). I confirm the medical history is correct. I understand the treatment, possible alternative treatments (including no treatment), and the benefits and risks of the proposed treatment. Common risks for dental procedures include swelling, infection, bleeding, vomiting, and biting of the lip. More serious complications are unlikely but can occur. All of my questions about the procedures have been answered in a satisfactory manner. Furthermore, by signing this, I agree to be responsible for full payment of all fees for dental services performed on the above mentioned patient.

Signature _____ Witness _____

Relationship _____ Witness _____