MailouxDentistry
WHERE SMILES BEGIN

CHILD HEALTH INFORMATION

Child's name: _____ Date of Birth: ___ / ___ / ___
FIRST MIDDLE LAST

Sex: M F Child's Doctor/Pediatrician: _____

Has the child been seen by another dentist? Y N If yes, when was their last visit? _____

Name of previous dentist: _____

Is your child currently having dental problems? Y N Explain: _____

_____

List any serious operations/illness/syndrome/medical conditions your child has/had:

_____

Please circle if your child has/had any of the following:

Heart Murmur	Heart Disease	Tuberculosis	Congenital Heart Defects
Hepatitis	Asthma	Rheumatic Fever	Cancer/Tumor
Diabetes	Bleeding Disorder	Seizures/Epilepsy	HIV/AIDS
Autism	ADD, ADHD		

Allergies (please list): _____

Medications (please list): _____

Responsible Party Name: _____ Phone Number: _____

Address: _____

Guardian Signature: _____ Doctor Signature: _____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ___ / ___ / ___

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____

DO YOU HAVE OTHER DENTAL COVERAGE?

No Yes, please complete the following:

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ___ / ___ / ___

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____