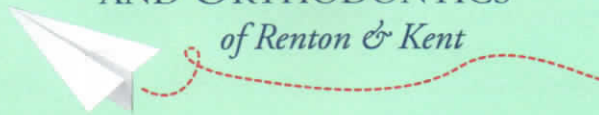


O'BRIEN CHILDREN'S DENTISTRY AND ORTHODONTICS



The following information is for our records only and will be considered confidential. Thank you for filling out both sides of this form completely...it will help us to give your child the best dental care possible.

Date _____
Child's Full Legal Name _____ Nickname _____
Address _____ City, State, Zip _____
Preferred Contact Phone _____ How long at this address? _____ With whom does child live? _____
Child's Age _____ Birthdate _____ Male _____ Female _____
Name and age of sister(s) _____
Name and age of brother(s) _____
Previous Dentist _____ Phone number _____
Child's Physician _____ Phone number _____
Who is accompanying child today? _____ Relationship to child _____
Emergency Contact Person (not living with patient) _____ Phone # _____

Father's Name _____ Cell # _____
Home Address (if different) _____ Home Phone # (if different) _____
Employer _____ Work # _____
Occupation _____ How long? _____ Birthdate _____
E-mail _____ Social Security # _____

Mother's Name _____ Cell # _____
Home Address (if different) _____ Home Phone # (if different) _____
Employer _____ Work # _____
Occupation _____ How long? _____ Birthdate _____
E-mail _____ Social Security # _____

Parental marital status: Married Single Divorced Separated Widowed

INSURANCE INFORMATION

Primary Dental Insurance Co. _____ Secondary Dental Insurance Co. _____
Their phone _____ Their phone _____
Insured's Name _____ Insured's Name _____
Birthdate _____ SS# _____ Birthdate _____ SS# _____
Relationship to child _____ Relationship to child _____
Insured's I.D. # _____ Insured's I.D. # _____
Employer _____ Employer _____
Group # _____ Group # _____
or Local Union # _____ Plan # _____ or Local Union # _____ Plan # _____

(Over)

Because conditions in the mouth can be hereditary, it is helpful to know if your child is adopted. Yes No

Is your child allergic to or has had any unfavorable reactions to drugs, including antibiotics and local anesthetic solutions? Yes No

If yes, which ones? _____

Is your child taking medication at the present time? Yes No / If yes, which ones and for what reason? _____

Has your child ever been hospitalized? Yes No / If yes, when and for what reason? _____

If your child has, or has had, any of the following, please check:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> ADD/ADHD/Hyperactivity | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autism/Aspergers | <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Speech Impediment |
| <input type="checkbox"/> Blood/Bleeding Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Learning Disabilities | Other _____ |

Please describe any current medical treatment including drugs, pending surgery, recent injuries, special needs, or any other medical information we should be aware of that has not yet been discussed: _____

Is your child taking any form of fluoride (tablets, drops, mouth rinses or gels)? Yes No

If yes, which ones? _____

Does your child have any thumb sucking, finger sucking, lip biting, nail biting, nursing bottle or pacifier habits? Yes No

If yes, describe _____

Has your child been to a dental office previously? Yes No Was it a positive experience? _____

If yes, where and when? _____

Has your child received any injuries to the mouth or teeth? Yes No / If yes, when? _____

Has your child had a toothache recently? Yes No / If yes, specify area _____

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

Are there any special concerns you would like to discuss with the Doctor today? _____

Because your child is a minor, it is necessary to obtain a signed permission from the parent or guardian before any/all necessary dental treatment can be started. Authorization is hereby granted, and you will be responsible for any bill incurred on this child for dental treatment, regardless of pending dental insurance benefits. I understand that credit bureau reports may be obtained.

Signature of Parent or Guardian _____ Date _____