

PATIENT INFORMATION

Welcome and thank you for choosing our office. Please fill in your answers as thoroughly as possible. This will help in developing a complete dental program for your child. Of course, all information will be held in strict confidence.

PARENTS: CHILDREN WILL BE BROUGHT BACK ALONE FOR THEIR VISIT. THIS WILL ALLOW DR. FLORES AND HIS STAFF TO DEVOTE FULL ATTENTION TO YOUR CHILD. THANK YOU!

Child's Name _____ Age _____ Date of Birth _____ Sex M F

Street Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's Name _____ SS# _____ Date of Birth _____ Employed By _____

Father's Name _____ SS# _____ Date of Birth _____ Employed By _____

Names and ages of other children in family _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

(If yes to any, please explain)

Heart Murmur or Congenital Heart Defect	Y	N	Asthma	Y	N	Abnormal Bleeding/ Blood Disorders	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Any Operations	Y	N
Rheumatic Fever	Y	N	Tuberculosis (TB)	Y	N	Any Stays in Hospital	Y	N
HIV/AIDS	Y	N	Convulsions/Epilepsy	Y	N	Handicaps/Disabilities	Y	N
Blood Transfusions	Y	N	Allergies to Drugs	Y	N	Emotional/ Behavioral Disorders	Y	N
Sickle Cell Anemia	Y	N	Hearing Problems	Y	N	Kidney/Liver Problems	Y	N

Explanation: _____

List Medications Now Taking: _____

Physician's Name(s): _____

CONSENT

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed to fit to provide recommended treatment.

Parent/Guardian _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received a copy of this office's Notice of Privacy Practices.
Please Print

Signature _____ Date _____

