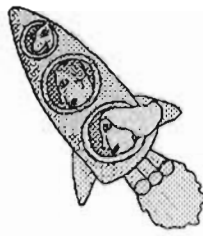
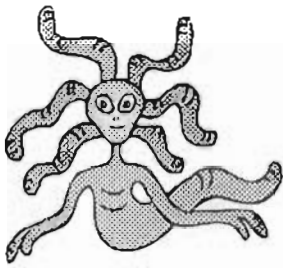


Welcome

We are pleased to welcome you to our office. Please take a few minutes to fill out this form completely. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your child's dental health.



Patient Information:

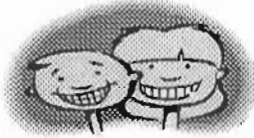
Name of Minor/Child: _____ /
Last First MI Preferred Name

DOB: ____ / ____ / ____ Age: _____ OM OF Home Phone: (____) ____ - ____

Home Address: _____
Street#/Name City State Zip

Name of School: _____ Level: _____

Special Interests/ Fictional Character(s): _____



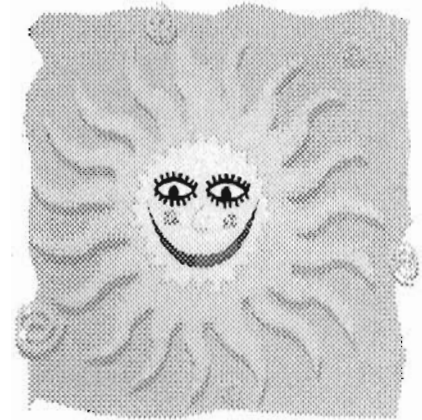
Father's/Guardian's Name: _____
OMarried OSingle ODivorced/Sep. ODeceased

Home Address: _____

Home Phone: (____) ____ - ____
(If different from patient)

Employer: _____ Work Phone: (____) ____ - ____
(If different from patient)

SSN: _____ DOB: _____



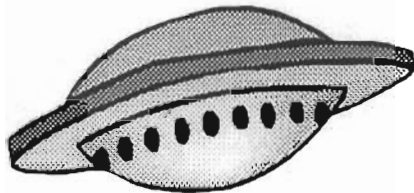
Mother's/Guardian's Name: _____
OMarried OSingle ODivorced/Sep. ODeceased

Home Address: _____

Home Phone: (____) ____ - ____
(If different from patient)

Employer: _____ Work Phone: (____) ____ - ____
(If different from patient)

SSN: _____ DOB: _____



Please Complete Both Sides...



Dental History:



Reason for today's visit: _____

Has your child ever had their teeth professionally cleaned? ON OY

Date (approximate) of last cleaning: ____/____/____ Were x-rays taken? ON OY

Has your child ever experienced an unfavorable reaction to dental care? ON OY

Is your child under the care of an orthodontist? ON OY Dr. _____

Does your child have/had any of the following oral habits? (please check ✓)
O Thumb Sucking to age ____
O Finger Sucking to age ____
O Pacifier to age ____



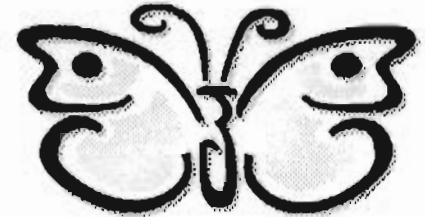
Medical History:

Physician's Name: _____ Phone No.: _____

Has your child had a serious illness or operation? ON OY

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

- AIDS, Anemia, Asthma, Blood Disease, Cancer, Chemotherapy, Cough, persistent, Diabetes, Epilepsy, Food Allergies, Heart Murmur, Heart Problems, Hemophilia/Abnormal Bleeding, Hepatitis, Jaw Pain, Kidney Disease or Malfunction, Liver Disease, Material Allergies (latex), Mitral Valve Prolapse, Nervous Problems, Rheumatic/Scarlet Fever, Spina Bifida, Surgical Implant, Tuberculosis



Any conditions not listed you would like brought to our attention: _____

Siblings &/or Pets

Please list name(s) of sibling(s) &/or pet(s):

- 1. _____ Age _____
2. _____ Age _____
3. _____ Age _____

Who may we thank for referring you to our office...

Name: _____

Address: _____

Authorization

I have read the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Perez to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform Dr. Perez.

I hereby give authorization as parent or legal guardian to Ricardo A. Perez, D.D.S., P.C., for the completion of all agreed upon dental services for my child.

I understand it is the policy of this office that treatment charges are to be paid upon completion of treatment and that a third party payment is not accepted.

Signature: _____ Relationship: _____ Date: _____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS ADVANCE NOTICE ...

