CHILD'S NAME	NICK NAME	BIRTH DATE
FATHER'S NAME	ADDRESS	HOME PHONE
EMPLOYED BY	SOCIAL SECURITY #	WORK PHONE
MOTHER'S NAME	ADDRESS	HOME PHONE
EMPLOYED BY	SOCIAL SECURITY #	WORK PHONE
PERSON FINANCIALLY RESPONSIBLE	ADDRESS	PHONE
PRIMARY INSURANCE COMPANY	INSURED'S NAME DOB	POLICY #
SECONDARY INSURANCE COMPANY	INSURED'S NAME DOB	POLICY #
METHOD OF PAYMENT	WHOM MAY WE THANK FOR REFERRING YOU?	

MEDICAL HISTORY

YES NO

❑ ❑ Is child seeing a Doctor for a medical condition? If yes, please explain. __________

Name and phone number of physician. __________

❑ ❑ Has child had any illness or surgery within the last five years? If yes, list date and please explain. __________

❑ ❑ Is child taking any drugs or medications? If yes, please list. __________

HAS CHILD EVER HAD:

YES NO

- ❑ ❑ Rheumatic fever
- ❑ ❑ Other heart problems
- ❑ ❑ Anemia
- ❑ ❑ Bleeding disorder
- ❑ ❑ Liver problems
- ❑ ❑ Asthma or other breathing problems
- ❑ ❑ Diabetes

YES NO

- ❑ ❑ Convulsions
- ❑ ❑ Fainting
- ❑ ❑ Kidney problems
- ❑ ❑ Emotional problems
- ❑ ❑ Allergies(please explain) __________
- ❑ ❑ Any other medical problems __________

DENTAL HISTORY

YES NO

❑ ❑ Is child having any discomfort? If so, please explain __________

❑ ❑ Is this child's first visit to a dentist? If not, last visit date __________

❑ ❑ Does child brush daily? How many times __________

❑ ❑ Does parent assist with brushing?

❑ ❑ Does child use home fluoride?

❑ ❑ Any injuries to mouth/teeth? If yes, please explain __________

❑ ❑ Any mouth habits: pacifier, thumbsucking, nail biting, mouthbreathing, nursing bottle? (Circle any that apply)

YES NO

❑ ❑ Have braces been worn? If yes, please explain __________

❑ ❑ Has child had any previous bad experiences with dentistry? __________

Comments __________

I, the parent or guardian, give consent to the performance of necessary dental care for the above child. Also, that I am responsible for the full fees charged to me for those dental services. If I have dental insurance, I am responsible for the balance not paid by my insurance. I hereby authorize payment directly to Dr. Sesemann of the insurance benefits otherwise payable to me.

I hereby understand that it is the policy of the office that the person requesting treatment is financially responsible.

PATIENT'S (OR PARENT'S) SIGNATURE __________ DATE