

Patient Name _____

Medical Alert _____

CHILD HISTORY

- | | | | |
|----|--|-----|----|
| 1. | Has child been under the care of a medical doctor recently?
If yes, for what? _____
_____ | YES | NO |
| | Child's physician _____
Phone number _____ | | |
| 2. | Is child on medication now?
If yes, what? _____ | YES | NO |
| 3. | Is child sensitive or allergic to anything?
If yes, what? _____ | YES | NO |
| 4. | Does child have history of heart trouble, rheumatic fever, epilepsy,
diabetes, bleeding, or psychological disorder?
If yes, what? _____
_____ | | |
| 5. | Is child living in area with well water? | YES | NO |
| 6. | Is child taking supplemental fluoride? | YES | NO |
| 7. | Has your child ever experienced unfavorable reaction
from any previous dental or medical care? | YES | NO |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you will have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

(over)



PATIENT INFORMATION		
Date		
Name		
Address		
City	State	Zip
Home Phone No.		
Birthdate	Age	Social Security
School	Grade	



DENTAL INSURANCE	
PRIMARY CARRIER	
Insurance Company	
Employee	
Group No.	
Emp. Birthdate	
Emp. Social Security No.	
Date Employed	
SECONDARY CARRIER	
Insurance Company	
Employee	
Group No.	
Emp. Birthdate	
Emp. Social Security	
Date Employed	



ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
Name	
Address	
City	State Zip
Home Phone No.	Work No.
Your Name	
Occupation	
Employer	
Business Address	City
Business Telephone	Ext.
YOUR SPOUSE	
Name	
Occupation	
Employer	
Business Address	City
Business Telephone	Ext.



GETTING TO KNOW YOU	
Is Another Member of your Family or a Relative a Patient at our Office?	
Their Name	
Referred to us by:	
Person to Contact for Emergency	
Phone No.	
Address	
City	State Zip
Closest Relative not living with you	
Phone No.	
Address	
City	State Zip

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to Dr. Linville of Dental Benefits, if any, otherwise payable to me _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Linville to release any information acquired in the course of my examination or treatment to specific insurance carriers involved in processing and collection of this claim _____