Susanne Parrish, D.D.S. ~ Lawrence Brown D.D.S.

CHILDREN'S DENTAL ASSOCIATES

CHILD'S NAME: LAST______________FIRST_________________NICKNAME ______________ SEX_______

ADDRESS___________________________CITY___________________ ZIP CODE__________ BIRTHDATE __________

MOTHER'S NAME___________________________ADDRESS____

HOME PHONE (_____)_______________ CELL PHONE(_____)_____________ EMAIL____________________@________

SS#_________________DOB ___________ OCCUPATION________________ EMPLOYER ________________________

DENTAL INS. CO.______________________________ POLICY NUMBER_____________________________

FATHER'S NAME_____________________________ADDRESS____

HOME PHONE (_____)_______________ CELL PHONE(_____)_____________ EMAIL____________________@________

SS#_________________DOB ___________ OCCUPATION________________ EMPLOYER ________________________

DENTAL INS. CO.______________________________ POLICY NUMBER_____________________________

DOES CHILD LIVE WITH MOM________ DAD__________ BOTH___________ OTHER____________________

DENTAL HISTORY: IS THIS HIS/HER FIRST DENTAL VISIT?____
HAS THE CHILD HAD DENTAL WORK DONE, IF SO WHAT?____
NAME OF PREVIOUS DENTIST____
LIST ANY PROBLEMS THAT CONCERN YOU:____

SOURCE OF DRINKING WATER: CITY___________ WELL_______________ OTHER________________________

MEDICAL HISTORY: PHYSICIAN'S NAME__________________________________LOCATION_________________

ALLERGIES: YES OR NO______IF SO, LIST ALL:____
TAKING ANY MEDICINES NOW AND WHY?____
DOES THE CHILD HAVE A HISTORY OF: SEIZURES_________ASTHMA____________ADHD__________________
DIABETES_____________________HIV/AIDS_______________________LEARNING DISABILITIES______________
HEART PROBLEMS___________________________PRE-MEDS REQUIRED YES/NO__________________________
BLOOD TRANSFUSION__________________________CEREBRAL PALSY__________________________________
SURGERY____________________DELAYED DEVELOPMENT___________________OTHER___________________

CHILD'S HOBBIES AND INTERESTS____
NAME OF SCHOOL/GRADE____
NAMES AND AGES OF SIBLINGS____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?____

I (WE) HEREBY GIVE AUTHORIZATION AS A PATIENT/GUARDIAN TO CHILDREN'S DENTAL ASSOCIATES FOR THE COMPLETION OF ALL AGREED UPON DENTAL SERVICES FOR MY CHILD AND AGREE TO BECOME PERSONALLY RESPONSIBLE FOR SUCH FINANCIAL OBLIGATIONS INCURRED. OUR POLICY IS FOR PAYMENT TO BE MADE AT TIME OF SERVICE. WE WILL BE HAPPY TO ASSIST YOU IN FILING YOUR INSURANCE CLAIM.

SIGNATURE________________________ RELATIONSHIP_______________________DATE___________

ASSIGNMENT AND RELEASE:
I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH ____
AND ASSIGN DIRECTLY TO DR __________________________ALL DENTAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE____DATE________________________