

**MINOR
CONFIDENTIAL**



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Thank you for choosing us as your dental provider. To provide you with dental services, we require the following information. Please print legibly. Please complete all information in-full so we may better serve you.

Minor's Information:

1) Name of Minor: _____ 2) Minor's School: _____ City: _____
last first middle initial

3) Please enter today's date: / / 4) Birthdate of Minor: / / 5) Age: _____ 6) Sex: / M F

month day year month day year

Mother's Information:

7) Name: _____
last first middle initial

8) Home address: _____
street Apt.#

city state zip

9) Home telephone #: ()

10) Birth-date: / / 11) Age:
month day year

To help verify your insurance coverage, we require the following:

12) Social Security #: - - 13) Driver's license #: -

14) Mother's employer: _____

15) Work address: _____
street Apt.#

city state zip

16) Work Telephone #: ()

17) Dental Insurance at Mother's employer:

18) Insurance Plan #: 18a) Group #: (if applicable)

31) Who referred you to our office? _____

32) Has any member of your immediate family been seen by us in our Lakewood or Cerritos offices? YES NO
Who? _____ When? _____

33) When was your child's last visit to a dentist?
Who? _____ Reason? _____

34) What is your reason for visiting us today? _____

35) What would you change about your child's smile if you could? _____

Father's Information:

19) Name: _____
last first middle initial

20) Home address: _____
street Apt.#

city state zip

21) Home telephone #: ()

22) Birth-date: / / 23) Age:
month day year

To help verify your insurance coverage, we require the following:

24) Social Security #: - - 25) Driver's license #: -

26) Father's employer: _____

27) Work address: _____
street Apt.#

city state zip

28) Work Telephone #: ()

29) Dental Insurance at Father's employer:

30) Insurance Plan #: 30a) Group #: (if applicable)

FOR OFFICE USE ONLY	Patient's Ins. Effective date: _____	Spouse's Ins. Effective date: _____
	Guaranteed Eligibility Signed: _____	Guaranteed Eligibility Signed: _____

CHILD MEDICAL HISTORY

Please complete the following Child Medical History questions. All information is kept Confidential.

36) Is your child currently in good health? YES NO If no, please explain: _____

37) Does your child take any medications? YES NO Which? _____

38) Is your child allergic to anything? YES NO What? _____

38b) Is your child allergic to any medications? YES NO Which? _____

39) What is the name of your child's Physician? _____ City: _____ Phone #: _____

40) When was the last time your child visited a doctor? _____

41) Does your child have or ever had the following: (**Circle YES or NO to for each listed**)

- | | | |
|--|-------------------------------------|---|
| YES NO Arthritis or Rheumatism | YES NO Hepatitis | YES NO Thyroid problems |
| YES NO Rheumatic Fever | YES NO Hemopheliac | YES NO Headaches |
| YES NO Rheumatic Heart Disease | YES NO Fainting spells | YES NO Temporal Mandibular Disorder (TMD/TMJ) |
| YES NO Heart Defect or Murmur | YES NO Seizures | YES NO Drug or Alcohol addiction |
| YES NO Angina or Heart Attack | YES NO Anemia | YES NO Sexually transmitted disease |
| YES NO Pacemaker | YES NO Asthma | YES NO HIV or AIDS |
| YES NO Prosthetic Cardiac Valves | YES NO Glaucoma | YES NO Cancer or Tumor |
| YES NO Complex Cyanotic congenital heart disease | YES NO Stroke | YES NO Radiation treatment |
| YES NO Heart Surgery | YES NO Diabetes | YES NO Chemotherapy treatment |
| YES NO High Blood Pressure | YES NO Epilepsy | YES NO taken "Phen-Fen" |
| YES NO Pulmonary Shunts or conduits | YES NO Tuberculosis | YES NO taken Redux |
| YES NO Mitral Valve Prolapse | YES NO Sinus trouble | YES NO taken Cortisone |
| YES NO Leukemia | YES NO Joint replacement or Implant | YES NO Latex Allergy |
| | YES NO Kidney problems | |

42) Does your child have any other medical conditions we should be aware of? YES NO Explain: _____

43) For Females: A) Are you pregnant? YES NO C) Are you nursing? YES NO
B) Months pregnant: _____ D) Are you taking birth-control pills? YES NO

44) This is to certify that I have read and understand the above information. I have completed the requested information and have verified that it is correct and truthful. I have disclosed all information regarding my insurance. I understand that if I am not covered or am ineligible for insurance coverage, I will be responsible for the outstanding portion of fees. I consent to use of the above information for office purposes. I understand that I am responsible for notifying Lakewood Cerritos Dental Centers if there are any changes to the above information. I authorize my child to be examined by Lakewood Cerritos Dental Centers.

45) Parent's Signature: X 46) Date: / /

FOR OFFICE USE ONLY	I have reviewed this patient's information and medical history above.	FOR OFFICE USE ONLY
Doctor's Signature: _____	Date: <u> / / </u>	