

PHANORD

& ASSOCIATES P. A.

We are pleased to welcome you and your child to our practice.

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

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			CASSIAN COLOR	
Name of Minor/Child	First Name	Middle Initial	Sex M F Age _	
Nickname			Cell Phone ()	
	_ Hobbies		Cell Friorie ()	
Home AddressStreet	City		State	Zip
Mailing Address				
Street	City		State	Zip
School Name		School	Phone ()	
Person financially responsible	Home Phone	()	Work Phone ()
Whom may we thank for referring you?			A THE SALE SERVICE	
Father's/Guardian's Name	N.	Nother's/Guardian's	Name	
Address (if different from patient's)			rom patient's)	
Home Phone () Work Pl	none () H	lome Phone () Work Phone ((if different from above
E-mail	E	-mail		
Employer	E	mployer		
Soc. Sec. # Birthdat	e S	oc. Sec. #	Birthdate	
Do you have dental insurance coverage for mi	nor/child? ☐ Yes ☐ No ☐	o you have dental in	nsurance coverage for minor/ch	nild? 🗆 Yes 🗆 No
Plan Name Phone () P	lan Name	Phone ()
Address	A	ddress		
Group # Policy #		Group #	Policy #	
Is your child eligible for treatment under Medic				

DENTAL HISTORY

INSURANCE

Date of last visit to a dentist For what service?. YES YES NO NO Has child complained about dental problems? Is fluoride taken in any form?..... Does child brush teeth daily?..... Any injuries to mouth, teeth, head? Any unhappy dental experiences? Does child use floss every day?..... Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?

	Minor/Child's Physician		Citv/S	State		Phone ()	F- 1
	Date of last physical examination						
	Date of last physical examin	audit		10		THE RESERVE	
	Is Minor/Child under care of physician now?			Medications			
₹	Receiving any medication of	r drugs?	0				
ST							
Ë					THE PARTY OF THE P		
MEDICAL HISTORY							
<u> </u>	Is there excessive bleeding	when cut?	0 0				TERM
	Has minor/child had any his	story of or difficulty with any of the	he following? If ye	es, please che	ck (🗸).		
	☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy		☐ Kidney Disease	☐ Rheumatic	Fever
	☐ Anemia	☐ Chicken Pox	☐ Fainting		☐ Liver Disease	☐ Sinus Prob	
	☐ Asthma	Convulsions	☐ Hearing Pr		☐ Measles	☐ Thyroid Dis	
2 E 1 E	☐ Bladder Problems	Diabetes	☐ Heart Prob	lems	☐ Mononucleosis	☐ Tuberculosi	S
	☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis		☐ Mumps	Other	
>	In the event of an emergence	cy, whom should we contact?					
SCI	in the event of an emergence	,,					
ERGENCY ONTACT	Name		Relati	ionship		Phone ()	- 1
CO		THE SHARE				. Phone ()	
E	Name		Relat	ionship		. Phone ()	-
	To the best of my knowledge	e the above information is com	polete and correct	Lunderstand	that it is my responsibil	lity to inform my doctor i	f my minor
AUTHORIZATION	child ever has a change in I Minor/Child Consent I am the parent, guardian, of and there are no court orde hereby request and authoriz child named above, includin which are deemed advisal treatment is rendered. Insurance Assignment an I certify that my dependent and assign directly to Dr. otherwise payable to me fe whether or not paid by insu The above-named doctor m named Insurance Companinsurance benefits or the be is completed or one year fr	ers now in effect that prohibit more the dental staff to perform near the dental staff to perform the date signed below.	Please the from signing the the cessary dental se administration of a not I am present Name of Ins stand that I am file y signature on all care information a purpose of obtain ices. This consent	e Print Name of is consent. I dervices for the anesthetics, t when the urance Companal insurance all insurance all insurance sub and may disclaning payment	Minor/Child (o) (y(ies)) ance benefits, if any, onsible for all charges missions. Information to for services and determined the current treatment process.	the above-	f my minor
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