Cedar View Pediatric Dentistry

Patient: First Name ______________________ Last Name ______________________ Male/Female

Birth Date ____________________ Age __________ Email ________________________________

Mailing Address __________________________________ City, State, Zip ____________________

Mother: ____________________________ D.O.B _________________ SSN ________________

Phone __________________ Employer ______________________ Work Phone _______________

Father: ____________________________ D.O.B _________________ SSN ________________

Phone __________________ Employer ______________________ Work Phone _______________

Emergency Contact: _______________________________ Phone _________________________
(Someone not living in the home)

***Who may we thank for referring you to our office?** ______________________________________

Primary Dental Insurance: __________________________ Subscriber ______________________
Policy Number __________________________________ Group Number ____________________

Secondary Dental Insurance: ________________________ Subscriber ______________________
Policy Number __________________________________ Group Number ____________________

Medical History: Physician __________________________ Phone _________________________
Current Medications ____
Traumatic Medical/Dental Injuries ____
Hospitalized? ________ Reason ____________________________________ Date ____________

Circle ALL that apply

Autism	ADHD	Aids/HIV	Anemia	Artificial Joints	Asthma
Blood Disease	Behavior Problems	Cancer	Ear Infections	Tubes in Ears	Endocrine Problems
Fainting	Hearing/Sight	Heart Murmur	Heart Condition	Head Injury	Head aches
Kidney Disease	Learning Disorder	Liver Disease	Mental Disorder	Developmentally Delayed	GI System
Radiation Treatment	Respiratory Problems	Respiratory Treatment	Rheumatic Fever	Seizures	Tuberculosis

Allergies/Adverse Reactions to Medications ____
Frequent Infections ____
Blood Transfusion (dates) ____
Congenital Birth Defects ____

I hereby authorize all doctors, assistants, or auxiliaries associated with Cedar View Pediatric Dentistry to complete any necessary treatment on my child or patient that I am responsible for. I have read all above information and completed to the best of my knowledge.

_____________________________________ _____________________________

Signature Parent/Guardian Date