JOHN H. PERRIN, D.M.D., P.A.

Date: _____

ABOUT YOUR CHILD:

Name: _____ Date of Birth: _____/_____/_____
Last First Middle Init. MM DD YY

Nickname: _____ E-Mail Address: _____

Address: _____
Street Apt # City State Zip

SSN: _____ Male / Female Home Phone: _____

Would you like E-Mail communication regarding dental appointments? Yes_____ No_____

Previous/Present Dentist: _____ Phone No.: _____

Date of last visit: _____ Are you: Parent / Legal Guardian / Grandparent / Stepparent _____

ABOUT YOU:

Name: _____ Date of Birth: _____/_____/_____
Last First Middle Init. MM DD YY

SSN: _____ Work Phone: _____

Employer: _____ Occupation: _____

May we call you at work to confirm your child's appointments? Yes / No
Are you the party responsible for payment of your child's dental services? Yes / No

If No, please provide the following information for the responsible party:
Name: _____ Date of Birth: _____/_____/_____
MM DD YY

Address: _____
Street City State Zip

SSN: _____ Home Phone: _____

Employer: _____ Work Phone: _____

ABOUT YOUR CHILD'S INSURANCE:

Insurance Name: _____ Phone No.: _____

Policy Holder's Name: _____ Relationship to Patient: Spouse / Parent

Policy Holder's Birthdate: _____/_____/_____ SSN: _____

Policy Number: _____ Group Number: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my health status. I authorize Dr. John Perrin and his dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____
Signature

Patient's Name: _____ Date: _____

MEDICAL HISTORY

Have your child been under the care of a medical doctor in the past two years? Yes No
If so, please provide the following information:

Doctor's Name	Treatment/Medical Condition	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications taken in the last six months: _____
_____

Is he/she sensitive or allergic to any medications? Yes No
Please list, including type of reaction: _____
_____

Women only:
Are you pregnant? Yes No If yes, what is your expected date of delivery? _____
Are you taking birth control pills? Yes No

Please mark any of the following conditions that have been diagnosed by a physician.

_____ Heart murmur
_____ Rheumatic fever
_____ Mitral valve prolapse
_____ Artificial heart valve
_____ High/Low blood pressure
_____ Heart failure
_____ Heart disease
_____ Angina
_____ Pacemaker
_____ Heart surgery (When: _____)
_____ Liver Disease
_____ Kidney disease
_____ Bleeding tendencies
_____ Hepatitis
_____ Jaundice
_____ G.I. disorder _____
_____ Prostate/Urinary tract disorders

_____ None known

_____ Artificial joint / pins / screws
_____ Cancer or tumor _____
_____ Leukemia
_____ Chemotherapy / Radiation
Date of last tx: _____
_____ Anemia
_____ Epilepsy or seizure disorder
_____ Emphysema
_____ Tuberculosis
_____ AIDS, HIV or ARC
_____ Diabetes
_____ Asthma
_____ Thyroid disease
_____ Arthritis
_____ Depression, anxiety
_____ Hemophilia
_____ Organ removal or transplant _____
_____ Glaucoma
_____ TMJ Dysfunction

Not listed: _____

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in my child's health or medications, I will notify the dentist at the next appointment without fail.

_____ _____
Signature of Parent or Guardian Signature of D.M.D.

Date of review: _____