thank you for selecting us.

Christine S. Lee, D.D.S.

Date _______________

Please fill out this form completely in ink. We strive to make each of your child's visits pleasant and comfortable.

Your Child

Child's Name ______________________ Birthdate ____________ Sex ________ Age ________

Child's Address ______________________ City ____________ State ________ Zip ________

Phone (_____) ______________________ Number of children in the family ______________

Referred by ____

Primary Insurance

Insurance Co. ______________________________ Group # ______________

Ins. Co. Address ______________________ City ____________ State ________ Zip ________

Insured's Name ______________________________ Relationship ______________

Birthdate ______________________ Social Security # ______________________

Employer ______________________ Address ______________________

Additional Insurance

Insurance Co. ______________________________ Group # ______________

Ins. Co. Address ______________________ City ____________ State ________ Zip ________

Insured's Name ______________________________ Relationship ______________

Birthdate ______________________ Social Security # ______________________

Employer ______________________ Address ______________________

Parent Information ■ Mother ■ Stepmother ■ Guardian

Name ______________________________ Work Phone (_____) ______________

Address ______________________________ Home Phone (_____) ______________

Employer ______________________________ Occupation ______________

Employer's Address ______________________ City ____________ State ________ Zip ________

Birthdate ______________________ Social Security # ______________________

Parent Information ■ Father ■ Stepfather ■ Guardian

Name ______________________________ Work Phone (_____) ______________

Address ______________________________ Home Phone (_____) ______________

Employer ______________________________ Occupation ______________

Employer's Address ______________________ City ____________ State ________ Zip ________

Birthdate ______________________ Social Security # ______________________

Person Financially Responsible ■ Mother ■ Father ■ Other If other, complete the following.

Name ______________________________ Relationship ______________

Address ______________________ City ____________ State ________ Zip ________

Phone (_____) ______________________

Over, Please

Dental/Medical Health History (confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with dental care your child receives. Please answer each of the following questions completely.

Date of Last Dental Visit ____________ Previous Dentist ____________

Address ____________ City ____________ State ________ Zip ______

Has your child had difficulty with previous dental visits? ❑ Yes ❑ No

How often does your child brush? ____________ How often does your child floss? ____________

	Yes	No
Is your child's water fluoridated?	❑ Yes	❑ No
Does your child take fluoride supplements?	❑ Yes	❑ No
Does your child:		
Suck Thumb/Finger	❑ Yes	❑ No
Suck/Bite Lip	❑ Yes	❑ No
Bite/Chew Nails	❑ Yes	❑ No
Chew Hard Objects (pencils, etc.)	❑ Yes	❑ No
Grind Teeth	❑ Yes	❑ No
Clench Jaws	❑ Yes	❑ No
Has your child ever had a reaction to drugs/medicines?		
Penicillin	❑ Yes	❑ No
Novocaine	❑ Yes	❑ No
Sedatives	❑ Yes	❑ No
Immunizations	❑ Yes	❑ No
Latex	❑ Yes	❑ No

Other allergies ____________

Has your child ever had any of the following:		
Asthma	❑ Yes	❑ No
Behavioral Disorders	❑ Yes	❑ No
Handicaps/Disabilities	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No
Abnormal Bleeding	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Stomach, Liver or Kidney Problems	❑ Yes	❑ No
Convulsions/Epilepsy	❑ Yes	❑ No

Child's Physician ____________ Phone (_____) ____________

Address ____________ City ____________ State ________ Zip ______

Previous Hospitalizations/Surgeries/Serious Illnesses: ____________ When? ____________

____

____

Is your child currently taking any medications? ❑ Yes ❑ No (If Yes, please list) ____________

Please explain any medical or behavioral problems that your child has: ____________

____

____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. A fee may be assessed for broken/missed appointments and for delinquent accounts.

Signature of Parent or Guardian ____________ Date ____________