CHILD
CONFIDENTIAL PATIENT INFORMATION

ROBERT J. HELLIGE, D.D.S.
ROY H. REINARMAN, D.M.D.

PERSONAL INFORMATION

Date______________________

Child's Name:______________________________Preferred Name: ______________Date of Birth_____________

Parent's Name: ____

Address:____
(If P.O. Box, please include street address) Street City State Zip

Telephone: ____ Parents Cell #____________________________

Father's Employer:_____________________________________ Business Telephone_______________________

Mother's Employer:____________________________________ Business Telephone_______________________

Referred by:_____________________________, we would like to thank them. ❑ Family ❑ Co-Worker
❑ Neighbor ❑ Insurance ❑ Phone Book ❑ Newspaper ❑ Welcome Wagon ❑ Other________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:________________________________ Relationship:________________ S.S. #______________________

Address:____
Street City State Zip

Telephone: Home:____________________ Business:_____________________ Cell:________________________

I will be responsible for payment of the services furnished and agree to pay for such treatment regardless of insurance or any other third party involvement. I also agree, if the need arises for my account to be referred to collection, to pay all agency fees, court costs, attorney's and legal fees.

Signature ____ Date____________________

In case of divorce, the parent who schedules the dental treatment is **responsible** for payment regardless of any court document.

Signature ____ Date____________________

INSURANCE INFORMATION

Primary Insurance Co.:____

Employee:_____________________________ Relationship:_______________ S.S. #_______________________

Employer:____ Policy Number________________________

Employee's Date of Birth:____________________________

Secondary Insurance Co.:____

Employee:_____________________________ Relationship:_______________ S.S. #_______________________

Employer:____ Policy Number________________________

Employee's Date of Birth:____________________________

(over)

Update____

HEALTH INFORMATION

Personal Physician_____________________________M.D.____

Name Address

YES NO

____ ____ 1. Has your child been hospitalized within the past 2 years?

For what?____

____ ____ 2. Is your child currently being treated by a physician?

For what?____

____ ____ 3. Is your child taking any medication or drugs? What?______________________________________

____

____ ____ 4. Has your child experienced an unusual reaction or allergy to: ❑ anesthetic ❑ penicillin

❑ aspirin ❑ codeine ❑ other drug (please list) ______________________________

____ ____ 5. Has your child ever been seriously ill?

____ ____ 6. Is your child allergic to any metals? What?______________________________________

____ ____ 7. Has your child ever had a skin rash or other reaction to metal jewelry? To what?__________

____

____ ____ 8. Does your child bleed excessively upon injury or bruise easily?

____ ____ 9. Is your child fearful of dental or medical treatment?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOUR CHILD HAS HAD:

A. AIDS
B. Asthma
C. Cancer
D. Diabetes
E. Epilepsy
F. Heart Murmur
G. Heart Problems
H. Hepatitis
I. Jaundice
J. Kidney Problems
K. Lung Problems
L. Rheumatic Fever
M. Sinus Problems
N. Tuberculosis
O. Other Diseases

***If you circled either G or O describe condition ____

____

____

_____________________________ _______________ ______________________

Signature Date Reviewed By

____

____

____

____

____