MARINER DENTAL

About Your Child

Name:_____ Nickname:_____ Birthdate:___/___/___
Age _____ □ Male □ Female Social Security #_____
Special interests, sports, or hobbies:_____
Home Address:_____ Apt./Condo #_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Father's Name _____
Referred by:_____ Mother's Name _____

About You

Name:_____ Relationship to child:_____
Home Address:_____ City_____ State_____ Zip_____
Home # _____ Cell # _____ Work # _____ Ext. _____
Birthdate:__/__/__ Age:_____ SS #:_____ Driver's License _____

Primary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #_____ Group # (Plan, Local or Policy #) _____
Subscriber's Name:_____ Subscriber's Birthdate: ___/___/___ SS#_____
Subscriber's Employer:_____

Secondary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #_____ Group # (Plan, Local or Policy #) _____
Subscriber's Name:_____ Subscriber's Birthdate: ___/___/___ SS#_____
Subscriber's Employer:_____

Dental / Medical History

Has your child been to the dentist before? □ No □ Yes If yes, date of last visit:_____
Has your child had any problem when visiting a dentist before? □ No □ Yes If yes, please explain_____
_____
Are there any dental problems that you are aware of at present? □ No □ Yes If yes, please explain: _____
_____
Does your child brush his/her teeth daily? □ No □ Yes
Please rate your child's oral health. □Good □ Fair □ Poor
Is your child currently under the care of a physician? □ No □ Yes
Child's physician:_____ Phone # _____
Date of last visit: ___/___/___ Please rate your child's mental health. □ Good □ Fair □ Poor

In the event of an emergency, is there someone who lives near you that we should contact?
Name:_____ Relationship:_____
Work #_____ Ext:_____ Home #_____

Has your child ever had any of the following medical conditions or problems?

Y N Heat Murmur	Y N Heart problems of any kind	Y N Seizures/Epilepsy
Y N Cancer	Y N Diabetes	Y N Rheumatic Fever
Y N HIV/AIDS	Y N Hemophilia	Y N Bleeding Problems
Y N Hearing Impairment	Y N Hyperactivity	Y N Breathing Problems

Does your child have any known allergies? □ No □ Yes If yes, please explain_____
_____
Has your child ever been hospitalized? □ No □ Yes If yes, please explain _____
_____
Does you child have any medical conditions not listed? □ No □ Yes If yes, please explain _____
_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of parent or guardian _____ Date _____