



PLEASE COMPLETE BOTH SIDES

Name (First) (Middle) (Last) Sex M F Nickname

Address (Street) (City) (Zip Code) Home Phone ( ) -

Date of Birth Height Weight

Father Work Phone ( ) -

Employed by Address

Mother Work Phone ( ) -

Employed by Address

Referred to our office by

Please indicate which of the following your child has had or has at present. Please check "yes" or "no" to each item.

- Heart Trouble, Rheumatic fever, Diabetes, Asthma, Anemia, Epilepsy, Tuberculosis, Kidney problems, Liver problems, Any other medical conditions, Measels, Scarlet fever, Chicken pox, Mumps, Whopping cough, Tonsils removed, Adenoids removed, Any illness resulting in high fever before age 2?, Others, Any recent surgery or hospitalization?, Taking any medications?

Is your child:

- In good health?, Subject to profuse bleeding?, Subject to nervous disorders?, Subject to fainting or dizziness?, Sensitive or allergic to any drug?, Any other allergies?

Does your child have any of these habits:

- Mouth breathing?, Thumb sucking?, Pacifier?

Name of Physician Phone ( ) -

Date of last Medical Examination Give age child walked Talked

When was the last visit to dentist Service received

Has your child experienced any unfavorable reaction to past dental care: yes no Medical care: yes no

How often are teeth brushed By whom

Name of Previous Dentist Phone ( ) -

Hobbies & Interests

# DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Policy Holder _____	Policy Holder _____
Date of Birth _____	Date of Birth _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____
Group # _____	Group # _____
SS#/ID# _____	SS#/ID# _____
Name of Insurance Co. _____	Name of Insurance Co. _____
Address _____ _____	Address _____ _____
Phone # ( _____ ) _____ - _____	Phone # ( _____ ) _____ - _____

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge.

Because \_\_\_\_\_ is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental service can be started and accomplished by Dalin-Feigenbaum Dental Associates, Ltd. Furthermore, I will be responsible for any fees incurred for this child for dental treatment. Authorization is hereby granted:

\_\_\_\_\_  
Signature (Parent or Guardian)

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*\*You May Refuse to Sign This Acknowledgement\*\*

I, (parent/guardian) \_\_\_\_\_, have been made aware  
of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature (Parent or Guardian)

\_\_\_\_\_  
Date