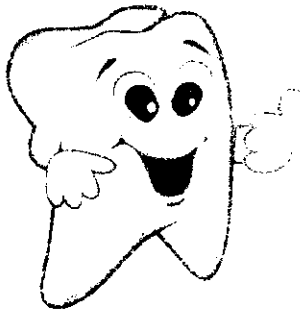


Welcome to SJ Family Dental

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Patient Information:

Date: _____

Child's Name: _____ _____
First Last

Date of Birth ____/____/_____

Address: _____
Street Apt

_____
City State Zip Code

Mother's Name: _____ Cell ( ) _____

Father's Name _____ Cell ( ) _____

Email: _____ How did you hear of us? _____

Who is accompanying the child today? _____

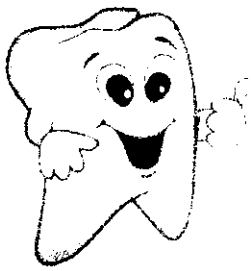
Insurance Information:

Name of the insurance _____ ID #_____

Important

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insura benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatments or examinations rendered, to my insurance company.

Signature_____ Date: _____



Medical History:

Child's Physician: _____ Date of last Visit: _____

Is the child currently in pain? _____

Does the child require antibiotics before dental treatment? _____

Has the child ever had any surgery? _____

Has the child been hospitalized? _____

Has the child ever experienced any medical problems? _____

Is the child allergic to any medications? _____

Has the child ever experienced any of the following medical problems?

_Y _ N HIV	__Y __N Measles
_Y _ N Anemia	__ Y ___N Diabetes
_Y __N Asthma	__ Y. __N Heart Murmur
_Y __N Cancer	__ Y __N Autism

Dental History:

Previous /Present Dentist:_____ Date of the last visit: _____

Has the child ever had any serious or difficult problems associated with previous dental work?

_____

Does the child have any habits? _____

_____

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

_____ _____

Signature of Parent or Guardian Date