

Frank Enriquez, D.D.S. & Nick Brajevich, D.D.S



Welcome to our practice!

Today's date: _____

Child's info

Name (first & last) _____ Nickname: _____

Birthdate: _____ age: _____ sex: _____ SS # _____ - _____ - _____

School: _____ grade: _____

Home Address: _____

(street) _____ (city) _____ (zip) _____

___ Mother ___ Stepmother ___ Guardian

Name: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ SS#: _____ - _____ - _____

Employer: _____

Occupation: _____ how long held? _____

DL# _____ email address: _____

___ Father ___ Stepfather ___ Guardian

Name: _____

Home phone: (____) _____ Work phone: (____) _____

Cell phone: (____) _____ SS#: _____ - _____ - _____

Employer: _____

Occupation: _____ how long held? _____

DL# _____ email address: _____

Parent's Marital Status

___ Married ___ Separated ___ Divorced ___ Single ___ Widowed

*** Responsible Party (if different from parents)**

Name: _____ Relationship: _____

Address: _____

(street) _____ (city) _____ (zip) _____

SS# _____ - _____ - _____ DL# _____

Email address: _____

Home phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

* who may we contact in case of emergency? _____

who may we thank for this referral? _____

Primary Dental Insurance

Insured's Name: _____ Relationship: _____

Birthdate: _____ SS#: _____

Ins. Company _____ Group # _____

Additional Insurance

Insured's Name: _____ Relationship: _____

Birthdate: _____ SS#: _____

Ins. Company: _____ Group # _____

(OVER)

Dental History

What would you like us to do for your child today? _____

Previous Dentist: _____ date of last dental care: _____

Has your child ever experienced a mouth or chin injury? _____

Check all that apply: speech difficulty, thumb/pacifier habit, jaw pain, grinds teeth

*other (please specify) _____

Has your child ever experienced an adverse reaction during a dental/medical procedure? Yes No

* (if yes, explain) _____

Other info. about your child's previous treatment _____

Medical History

Child's Physician: _____ phone: _____

Has child has any serious illness or operations? No Yes, if so what? _____

Has child ever had blood transfusion? No Yes, if so approx. date _____

Please check yes or no to all of the following conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aids/HIV + | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Digestive Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing impaired | <input type="checkbox"/> Y <input type="checkbox"/> N Special Needs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Brain Injury | <input type="checkbox"/> Y <input type="checkbox"/> N Autism |
| <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Down's Syndrome | |

Add'l explanations/comments _____

List medications your child is taking, if any: _____

Food allergies: _____

Drug allergies: _____

Material allergies: (ex.- latex) _____

Family Information

- Names of siblings: 1. _____ age _____ grade _____
 2. _____ age _____ grade _____
 3. _____ age _____ grade _____
 4. _____ age _____ grade _____

*Consent: I hereby authorize that all necessary dental services be rendered for _____

Signature _____ relationship _____ Date: _____ (patient's name)

*consent shall remain in force and in effect until cancelled.

Authorization: I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all information necessary to secure the payment of benefits.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

The difference (if any) between amounts paid by your insurance (where there is an assignment of benefits) and the amount billed is your responsibility.

Charges not paid within 90 days may be subjected to a "late payment" fee of 1.5% per month (18% annual percentage rate) until paid in full. Future services may be refused until the amount outstanding is no longer delinquent. Minimum "late payment" fee is 50 cents.

I am aware that there is a \$75 missed appointment fee for cancellation without 24 hour notice.

Signature of person responsible for account _____

Reviewed by: Nick Brajevich, D.D.S. _____ Frank Enriquez, D.D.S. _____