



Dalín Dental Associates

**PLEASE COMPLETE BOTH SIDES**

Name \_\_\_\_\_ |  M  F | Nickname \_\_\_\_\_  
(First) (Middle) (Last) Sex

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

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 ..... <input type="checkbox"/> yes <input type="checkbox"/> no                | Measels..... <input type="checkbox"/> yes <input type="checkbox"/> no   |
| Rheumatic fever..... <input type="checkbox"/> yes <input type="checkbox"/> no               | Scarlet fever..... <input type="checkbox"/> yes <input type="checkbox"/> no                                   |
| Diabetes..... <input type="checkbox"/> yes <input type="checkbox"/> no                      | Chicken pox ..... <input type="checkbox"/> yes <input type="checkbox"/> no                                    |
| Asthma ..... <input type="checkbox"/> yes <input type="checkbox"/> no                       | Mumps..... <input type="checkbox"/> yes <input type="checkbox"/> no   |
| Anemia..... <input type="checkbox"/> yes <input type="checkbox"/> no                        | Whooping cough..... <input type="checkbox"/> yes <input type="checkbox"/> no                                  |
| Epilepsy..... <input type="checkbox"/> yes <input type="checkbox"/> no                      | Tonsils removed..... <input type="checkbox"/> yes <input type="checkbox"/> no                                 |
| Tuberculosis..... <input type="checkbox"/> yes <input type="checkbox"/> no                  | Adenoids removed..... <input type="checkbox"/> yes <input type="checkbox"/> no                                |
| Kidney problems ..... <input type="checkbox"/> yes <input type="checkbox"/> no              | Any illness resulting in high fever before age 2?... <input type="checkbox"/> yes <input type="checkbox"/> no |
| Liver problems ..... <input type="checkbox"/> yes <input type="checkbox"/> no               | If yes, what? _____   |
| Any other medical conditions ..... <input type="checkbox"/> yes <input type="checkbox"/> no | Others ..... <input type="checkbox"/> yes <input type="checkbox"/> no   |
| If yes, what? _____   | If yes, what? _____   |

**Is your child:**

- In good health?.....  yes  no
- Subject to profuse bleeding? .....  yes  no
- Subject to nervous disorders? .....  yes  no
- Subject to fainting or dizziness? .....  yes  no
- Sensitive or allergic to any drug? .....  yes  no
- If yes, what? \_\_\_\_\_
- Any other allergies? .....  yes  no
- If yes, what? \_\_\_\_\_

- Any recent surgery or hospitalization? .....  yes  no
- If yes, explain? \_\_\_\_\_
- Taking any medications? .....  yes  no
- If yes, what? \_\_\_\_\_

**Does your child have any of these habits:**

- Mouth breathing? .....  yes  no
- Thumb sucking?.....  yes  no
- Pacifier?.....  yes  no

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 Dental Associates. 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