# Discovery Dental Centers

## Child (Ages 2-17 Only)

Child's Last Name _____ First Name_____MI_____
Address_____ City_____ State____ Zip_____
Birthdate _____ Age_____ Sex_____ Home Phone # _____
Father's Name_____ DOB_____ Soc. Sec. Number_____
Employed by_____ Work Phone_____ Cell Phone_____
Mother's Name_____ DOB_____ Soc. Sec. Number_____
Employed by_____ Work Phone_____ Cell Phone_____
Dental Insurance_____ Secondary Insurance_____
Name of Medical Doctor_____ Phone_____
Who is financially responsible for this bill?_____
Address_____

Payment is expected at the time the dental services are rendered.
Please check method of payment: Charge Card ☐ Check ☐ Cash ☐

Whom may we thank for referring to us? _____

DOES THE CHILD HAVE OR EVER HAD ANY OF THE FOLLOWING:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Blood Transfusion | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Seizures | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ |
| Abnormal Heart Rate | ☐ | ☐ | Allergic to: | | |
| Cancer or Tumor | ☐ | ☐ | Antibiotics/Penicillin | ☐ | ☐ |
| Valvular Disease | ☐ | ☐ | Local Anesthetic | ☐ | ☐ |
| Abnormal Bleeding | ☐ | ☐ | Other Medications | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Please specify_____ | | |
| AIDS/HIV Positive | ☐ | ☐ | _____ | | |
| Venereal Disease | ☐ | ☐ | Other Illnesses/Conditions | ☐ | ☐ |
| Emphysema/Asthma | ☐ | ☐ | Please specify_____ | | |
| Tuberculosis | ☐ | ☐ | Current Medications | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Please specify_____ | | |

**The undersigned hereby authorized the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature here authorizes my dentist to submit claims for benefits, services rendered, or to be rendered without obtaining my signature. This holds true for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.**

To the best of my knowledge, all of the preceding answers are true. If there is ever a change in my child's health, or if my medicines change, I will inform the dentist at the next appointment without fail.

**Signed_____Relation to child_____Date_____**

**_____ I acknowledge that I will be personally responsible for any and all charges not covered by my insurance.**