DAVID M. RIDER, D.M.D.

DATE_____**PATIENT'S NAME** _____

BIRTH DATE____-____-_____ MALE____ FEMALE____ PHONE_____

NAME YOU WISH YOUR CHILD TO BE CALLED_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PATIENT LIVES WITH: MOTHER_____FATHER_____BOTH_____ OTHER_____

IS THERE A SPECIFIC DENTAL PROBLEM AT THIS TIME? YES_____ NO_____
PLEASE DESCRIBE_____

FORMER DENTIST_____ DATE OF LAST VISIT_____

PHYSICIAN'S NAME_____ PHONE_____

IS PATIENT SENSITIVE/ALLERGIC TO <u>ANY</u> MEDICATIONS OR LATEX?_____
IF YES, PLEASE LIST:_____

IS PATIENT TAKING ANY MEDICINE AT THE PRESENT TIME?_____
IF YES, PLEASE LIST:_____

HAS PATIENT HAD ANY UNUSUAL EFFECT FROM ANY PREVIOUS DENTAL TREATMENT?_____

HAS PATIENT BEEN UNDER A PHYSICIANS CARE WITHIN THE PAST YEAR, IF SO PLEASE EXPLAIN_____

PLEASE ANSWER <u>YES</u> OR <u>NO</u> IF PATIENT HAS OR EVER HAD THE FOLLOWING:

Asthma_____Bronchitis_____Diabetes_____Allergies_____Convulsions_____
Tuberculosis_____HIV Virus_____Anemia_____Hepatitis_____
Heart Trouble_____Orthodontics_____Faints Easily_____Stomach Problems_____
Mitral Valve Prolapse_____ Pyorrhea or Bleeding Gums_____Venereal Disease_____
High Blood Pressure_____Excessive Bleeding_____Kidney Problems_____
Peridontal Surgery_____Scarlet Fever_____Rheumatic Fever_____

PLEASE DISCUSS ANY CURRENT MEDICAL TREATMENT, IMPENDING OPERATIONS OR ANY OTHER INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT.

PLEASE ANSWER <u>YES</u> OR <u>NO</u> FOR CONSENT TO THE FOLLOWING:

Fluoride Treatment_____
Radiographic Examination (X-Rays) _____
Local Anesthesia (Injection or "juice to make tooth sleep")_____
Nitrous Oxide Analgesia (Child will not sleep. This is air they breathe which allows them to relax.)_____

REFERRED BY_____

PLEASE SEE REVERSE SIDE

FATHER'S NAME_____ PHONE_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

ADDITIONAL PHONE NUMBERS: CELL_____ WORK_____

EMPLOYER_____OCCUPATION_____

MOTHER'S NAME_____ PHONE_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

ADDITIONAL PHONE NUMBERS: CELL_____ WORK_____

EMAIL ADDRESS_____

EMPLOYER_____OCCUPATION_____

NEAREST RELATIVE (NOT PARENT)_____ PHONE_____

INSURANCE INFORMATION

NAME OF PRIMARY PLAN HOLDER_____ PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

NAME OF DENTAL INS. COMPANY_____ GROUP #_____

INSURANCE PHONE #_____EMPLOYER_____

NAME OF SECONDARY PLAN HOLDER _____ PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY #_____ DATE OF BIRTH_____

NAME OF DENTAL INS. COMPANY_____ GROUP #_____

INSURANCE PHONE #_____EMPLOYER_____

I HAVE COMPLETED AND REVIEWED THE ABOVE QUESTIONNAIRE. ALL STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO ALL NECESSARY DENTAL TREATMENT OF MY CHILD. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

PARENT OR GUARDIAN'S SIGNATURE **DATE**