



Dr. Becky Maher
Healthy Smiles For A Lifetime!

Patient Information Child

Name _____ M / F Birthdate _____

Last

First

MI

Address _____

Street

City

St.

Zip

Home Phone _____ E-mail _____

General Dentist _____ Last Dental Visit _____ Other Family Treated Here _____

Who may we thank for referring you to our office _____

Parent Information

Person responsible for account _____

Parent #1 Name _____ Relationship to Patient _____ Marital Status _____

Address _____ # of Yrs. _____

Street

City

St.

Zip

Home Phone _____ Cell Phone _____ Wk Phone _____

E-mail _____

Parent #2 Name _____ Relationship to Patient _____ Marital Status _____

Address _____ # of Yrs. _____

Street

City

St.

Zip

Home Phone _____ Cell Phone _____ Wk Phone _____

E-mail _____

Insurance Information

Primary Insurance Co. _____ Phone # _____

Policy Holder's Name _____ SS# _____ Birthdate _____

Employer _____ Occupation _____ Group# _____ # Yrs. Employed _____

Secondary Insurance Co. _____ Phone # _____

Policy Holder's Name _____ SS# _____ Birthdate _____

Employer _____ Occupation _____ Group# _____ # Yrs. Employed _____

General Information

School _____ Hobbies _____

Siblings and their ages _____

Medical History

Physician _____ Last Visit _____ Phone # _____

Is the child currently under the care of your physician? Yes No If Yes, explain _____

Has the patient reached puberty or menstruation? Yes No Have Tonsils or Adenoids been removed Yes No

Has the patient ever experienced jaw joint pain/discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to: (select all that apply) Teeth Mouth Chin

Does/Has the patient ever had any of the following habits? Lip sucking/biting Nail biting Mouth breather

Prolonged bottle/pacifier Clenching/Grinding teeth Tongue thrusting Thumb/finger Sucking

Does the patient have speech problems? Yes No If yes, explain _____

Has the patient ever been evaluated for orthodontic treatment? _____

What are the main concerns that you would like to accomplish? _____

Is the child allergic to any of the following? Aspirin Codeine Erythromycin Latex Penicillin

Tetracycline Any metals/plastics

List any other allergies or sensitivities _____

List all medications the patient is currently taking:

List any serious medical conditions treated for:

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status.

I hereby authorize the release of any information for the purpose of insurance processing and dental diagnosing by the doctor.

I understand that where appropriate, credit bureau reports may be obtained.

Parent/Guardian signature _____ Date _____