

PREVENTIVE DENTAL HISTORY

HOW OFTEN DOES YOUR CHILD BRUSH?

IS TOOTH BRUSHING SUPERVISED? Yes No

IF SO, BY WHOM? _____

IS DENTAL FLOSS USED? Yes No

DOES YOUR CHILD RECEIVE...

- FLUORIDATED WATER
- BOTTLED WATER
- WELL WATER

DENTAL INSURANCE

PRIMARY INSURANCE _____ GROUP # _____

POLICY HOLDER NAME _____ MEMBERSHIP# _____

SECONDARY INSURANCE _____ GROUP # _____

POLICY HOLDER NAME _____ MEMBERSHIP# _____

PARENT/GUARDIAN INFORMATION

FATHER'S FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____

MOTHER'S FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____

IN CASE OF EMERGENCY PLEASE NOTIFY

RELATIVE: _____ PHONE: _____ CELL PHONE: _____

FRIEND: _____ PHONE: _____ CELL PHONE: _____

FRIEND: _____ PHONE: _____ CELL PHONE: _____

AUTHORIZATION FOR TREATMENT/PAYMENT OF SERVICES

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental service can be started and accomplished by Dr. Lents. Authorization is hereby granted as such, furthermore, I will be responsible for any bill incurred on this child for dental treatment.

SIGNED _____ DATE _____ RELATIONSHIP _____