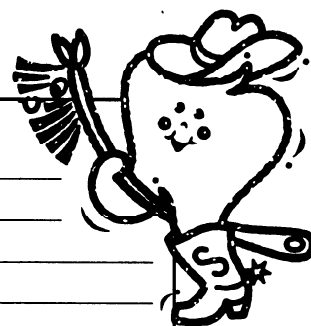




Welcome! _____
Thank you for selecting us!

Harry M. Suekert, DDS, PLLC
 Family and Cosmetic Dentistry

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.



Your Child

Child's Name _____ Sex _____ Age _____
 Nickname _____ Social Security # _____ Birthdate _____
 School _____ Grade _____
 Child's Home Address _____
 City, State, Zip _____ Phone _____

Parent or Guardian Information

Mother **Stepmother** **Guardian**

Name _____
 Home Phone _____ Work Phone _____
 Employer _____ Occupation _____
 Social Security # _____ DL # _____
 Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father **Stepfather** **Guardian**

Name _____
 Home Phone _____ Work Phone _____
 Employer _____ Occupation _____
 Social Security # _____ DL # _____
 Marital Status Single Married Separated Divorced Widowed

Who is Responsible for Making Appointments? _____

Responsible Party (If different from above.)

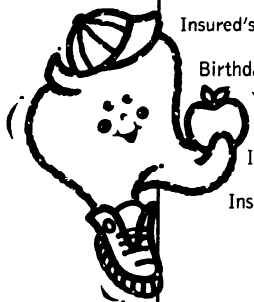
Name _____ Relationship _____
 Address _____
 City, State, Zip _____ Phone _____
 Social Security # _____ DL # _____

Primary Insurance

Insured's Name _____ Relationship _____
 Birthdate _____ Social Security # _____
 Employer _____ Occupation _____
 Insurance Co. _____ Group # _____ Employee # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____

Additional Insurance

Insured's Name _____ Relationship _____
 Birthdate _____ Social Security # _____
 Employer _____ Occupation _____
 Insurance Co. _____ Group # _____ Employee # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____



Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Clench Jaws Yes No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? Yes No

Has your child ever had any of the following:

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Handicaps/Disabilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach, Liver or Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convulsions/Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?
_____	_____
_____	_____

Is your child currently taking any medications? Yes No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard Care Credit Discover

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the office of Harry M. Suekert, DDS, PLLC of any changes in my child's medical status. I also authorize the dental staff to perform routine diagnostic and preventive dental services including, but not limited to examination, simple cleaning, x-rays, fluoride treatment and oral hygiene instruction. I also authorize Harry M. Suekert, DDS, PLLC to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Harry M. Suekert, DDS, PLLC any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature of Parent or Guardian _____ Date _____

Dentist's Review: _____

Signature _____ Date _____