Welcome to HORIZONS DENTAL

Child's Last Name: _____ First Name: _____ M.I. ___ Preferred Name:_____

Home Address: _____ City: _____ State: _____ Zip_____

Home Phone: (_____) _____ Cell Phone: (_____) _____ (to send appt reminders)

E-Mail Address_____@_____ ☐ Male ☐ Female

DOB: _____/_____/_____ Age: _____ SS#:_____-_____-_____

School: _____ Grade: _____ Who referred you to our office? _____

Parent/Guardian Name: _____ Relation _____

Home Address: _____ City: _____ State: _____ Zip_____

Home Phone: (___) _____ Work Phone: (___) _____ Ext___Cell Phone: (___) _____

DOB: ___/___/___ Guardian's SS#:_____-___-_____ Drivers License #: _____

Employer: _____How Long? _____ Occupation: _____

Employer's Address: _____City: _____ State:_____ Zip_____

Parent/Guardian Name: _____ Relation _____

Home Address: _____ City: _____ State: _____ Zip_____

Home Phone: (___) _____ Work Phone: (___) _____ Ext___Cell Phone: (___) _____

DOB: ___/___/___ Guardian's SS#:_____-___-_____ Drivers License #: _____

Employer: _____How Long? _____ Occupation: _____

Employer's Address: _____City: _____ State:_____ Zip_____

Primary Dental Insurance Coverage

Subscriber Name: _____ Relation_____

DOB: ___/___/___ SS#:_____ ID# _____ Group #: _____

Insured's Employer: _____

Insurance Company Name: _____ Phone: (_____) _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation_____

DOB: ___/___/___ SS#:_____ ID# _____ Group #: _____

Insured's Employer: _____

Insurance Company Name: _____ Phone: (_____) _____

TURN OVER

Child's Medical History

Please list all medications your child is currently taking _____

_____

Child's Medical Doctor: _____ Phone: _____

Does your child have or ever had any of the following diseases, medical conditions or procedures?

- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Defect
- ☐ Scarlet Fever
- ☐ Surgeries/Operations
- ☐ Cancer/Tumors
- ☐ Chemotherapy
- ☐ Jaw Problems

- ☐ Hearing Problems
- ☐ Tonsillitis
- ☐ Respiratory Problems
- ☐ Asthma/Difficulty Breathing
- ☐ Blood Transfusion
- ☐ Leukemia
- ☐ Anemia
- ☐Diabetes Hypoglycemia
- ☐ Hemophilia

- ☐ Abnormal Bleeding
- ☐ Cleft Lip/Palate
- ☐ Birth Defects
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis
- ☐ Artificial Bones or Joints
- ☐ Liver/Kidney/Organ Problems

- ☐ HIV+/AIDS/ARC
- ☐ Tuberculosis TB
- ☐ Psychiatric Problems
- ☐ Hyper Active/ADD
- ☐ Fainting
- ☐ Seizures/Epilepsy
- ☐ Cerebral Palsy
- ☐ Pregnancy

Please list any surgeries or medical conditions your child has or ever had: _____

_____

Is your child allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Sulfa

☐ Dental anesthetics ☐ Foods: _____ ☐ Others: _____

Has your child ever taken Ritalin? ☐ No ☐ Yes/How long? _____

Signature _____ Date _____/_____/_____

☐ Parent or Guardian