michael p. glinka d.d.s.
timothy d. voss d.d.s.

ACCOUNT _____ **DATE** ____/____/____

Child's Name: _____ Nickname: _____ Sex: ____ M ____ F

Date Of Birth: ____/____/____ Age: _____ Social Security Number: _____ - _____ - _____

Child's Physician/Pediatrician: _____

If Patient lives at a different address than Parent/Caregiver:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Purpose of Call: (Are any teeth bothering your child?): _____

DENTAL HISTORY:

Date of last Dental Care: _____ Where: _____

YES	NO	
☐	☐	1. Has either parent had a lot of decay, orthodontic problems, or periodontal disease?_____
☐	☐	2. Has your child had an unfavorable experience in a medical or dental office? _____
☐	☐	3. Do you consider your child to be high strung or nervous? _____
☐	☐	4. Has your child any history of thumb sucking, lip or nail biting? _____

MEDICAL HISTORY:

YES	NO	
☐	☐	1. Is your child taking any medicine? If yes, what _____
☐	☐	2. Has your child had any unfavorable reaction to drugs, including antibiotics and local anesthetic Solution?If Yes, Please explain: _____
☐	☐	3. Has your child ever received a blood transfusion or blood products?
☐	☐	4. Is your child adopted?
☐	☐	5. Are you covered by ADC, Medicaid, Crippled Children's Services, or Headstart? (circle agency)

For the following questions, circle and explain. Has your child had any history of:

Learning Disorders	Cerebral Palsy	Epilepsy	Heart Disorders	Heart Murmur
Rheumatic Fever	Blood disorders	Liver Disorders	Hepatitis	AIDS
Diabetes	Kidney Disorder	Asthma	Allergies	Latex Allergy

Explanations: _____

Whom may we thank for referring you to us? _____

Nearest relative other than parents, please indicate:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Because your child is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any dental service can be started and accomplished by Dr. Glinka and Dr. Voss. Authorization is hereby granted as such. I further agree and will comply to the policy that the parent or guardian bringing the child for treatment is financially responsible. Payment is expected at each visit.

Signed _____ Date _____

Child's Name: _____

ACCOUNT INFORMATION SECTION

Father's/Caregiver's Name: _____ Employer: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Father's/Caregiver's Birthday _____ / _____ / _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Mother's/Caregiver's Name: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Mother's/Caregiver's Birthday _____ / _____ / _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

For Billing Purposes, are parents (circle one):

Married Separated Divorced Single Partnered Deceased

Primary Dental Insurance Co.: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____ Group Name: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Secondary Dental Insurance Co.: _____

Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group #: _____ Group Name: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____