Judith Finkelman, DDS

ABOUT YOUR CHILD

NAME:_____
DOB:_____
SS#:_____
ADDRESS:_____
_____
CITY:_____ST____ZIP_____
PHONE #:_____
CELL PHONE #:_____
SEX: MALE OR FEMALE (CIRCLE ONE)

INSURANCE INFORMATION

CO.NAME:_____
ADDRESS:_____
_____
PHONE #:_____
INSURED'S ID:_____
INSURED'S NAME:_____
RELATION:_____DOB:_____
INSURED'S EMPLOYER:_____

CHILD'S FAMILY INFORMATION

MOTHER'S NAME:_____
FATHER'S NAME:_____
HOW MANY BROTHERS/SISTERS? _____
LEGAL GUARDIAN NAME:_____

RESPONSIBLE ACCOUNT INFORMATION

NAME:_____
BILLING ADDRESS:_____
_____
SS#:_____
DOB:_____DRIVERS LIC#:_____
CELL #:_____
WORK #:_____

HAS CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS (PLEASE CIRCLE):

Y N HEART MURMUR
Y N RHEUMATIC FEVER
Y N ARTIFICIAL HEART VALVES
Y N CONGENITAL HEART DEFECT
Y N SCARLET FEVER
Y N SURGERIES/OPERATIONS
Y N CANCER/TUMORS
Y N CHEMOTHERAPY
Y N JAW PROBLEMS
Y N HEARING PROBLEMS
Y N TONSILLITIS
Y N RESPIRATORY PROBLEMS
Y N ASTHMA
Y N BLOOD TRANSFUTION(S)
Y N LEUKEMIA/ANEMIA
Y N HEMOPHILIA
Y N DIABETES/HYPOGLYCEMIA
Y N ABNORMAL BLEEDING
Y N CLEFT LIP/PALATE
Y N BIRTH DEFECTS
Y N HIGH/LOW BLOOD PRESSURE
Y N HEPATITIS
Y N ARTIFICIAL BONES/JOINTS
Y N LIVER/KIDNEY PROBLEMS
Y N HIV+/AIDS/ARC
Y N TUBERCULOSIS TB
Y N PSYCHIATRIC PROBLEMS
Y N HYPER ACTIVE/ADD
Y N FAINTING/SEIZURES
Y N CEREBRAL PALSY

PLEASE LIST ANY OTHER MEDICAL PROBLEMS: _____
ARE THERE ANY KNOWN ALLERGIES: _____
ANYTHING DR. SHOULD KNOW ABOUT YOUR CHILD Y/N EXPLAIN:_____
PREVIOUS DENTIST NAME: _____ PHONE #:_____

SIGNATURE: _____ DATE: _____