

**MINOR  
CONFIDENTIAL**



update:
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Thank you for choosing us as your dental provider. To provide you with dental services, we require the following information. Please print legibly. Please complete all information in-full so we may better serve you.

**Minor's Information:**

1) Name of Minor: \_\_\_\_\_ 2) Minor's School: \_\_\_\_\_ City: \_\_\_\_\_  
last first middle initial

3) Please enter today's date:  /  /  4) Birthdate of Minor:  /  /  5) Age: \_\_\_\_\_ 6) Sex:  /  M F

month day year month day year

**Mother's Information:**

7) Name: \_\_\_\_\_  
last first middle initial

8) Home address: \_\_\_\_\_  
street Apt.#

city state zip

9) Home telephone #: ( )

10) Birth-date:  /  /  11) Age:

month day year

To help verify your insurance coverage, we require the following:

12) Social Security #:  -  -  13) Driver's license #:  -

14) Mother's employer: \_\_\_\_\_

15) Work address: \_\_\_\_\_  
street Apt.#

city state zip

16) Work Telephone #: ( )

17) Dental Insurance at Mother's employer:

18) Insurance Plan #:  18a) Group #: (if applicable)

31) Who referred you to our office? \_\_\_\_\_

32) Has any member of your immediate family been seen by us in our Lakewood or Cerritos offices? YES NO

Who? \_\_\_\_\_ When? \_\_\_\_\_

33) When was your child's last visit to a dentist? \_\_\_\_\_

Who? \_\_\_\_\_ Reason? \_\_\_\_\_

34) What is your reason for visiting us today? \_\_\_\_\_

35) What would you change about your child's smile if you could? \_\_\_\_\_

**Father's Information:**

19) Name: \_\_\_\_\_  
last first middle initial

20) Home address: \_\_\_\_\_  
street Apt.#

city state zip

21) Home telephone #: ( )

22) Birth-date:  /  /  23) Age:

month day year

To help verify your insurance coverage, we require the following:

24) Social Security #:  -  -  25) Driver's license #:  -

26) Father's employer: \_\_\_\_\_

27) Work address: \_\_\_\_\_  
street Apt.#

city state zip

28) Work Telephone #: ( )

29) Dental Insurance at Father's employer:

30) Insurance Plan #:  30a) Group #: (if applicable)

FOR OFFICE USE ONLY	Patient's Ins. Effective date: _____	Spouse's Ins. Effective date: _____
	Guaranteed Eligibility Signed: _____	Guaranteed Eligibility Signed: _____

# CHILD MEDICAL HISTORY

Please complete the following Child Medical History questions. All information is kept Confidential.

36) Is your child currently in good health? YES NO If no, please explain: \_\_\_\_\_

37) Does your child take any medications? YES NO Which? \_\_\_\_\_

38) Is your child allergic to anything? YES NO What? \_\_\_\_\_

38b) Is your child allergic to any medications? YES NO Which? \_\_\_\_\_

39) What is the name of your child's Physician? \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

40) When was the last time your child visited a doctor? \_\_\_\_\_

41) Does your child have or ever had the following: (**Circle YES or NO to for each listed**)

- |  |                                     |   |
|--|-------------------------------------|---|
| YES NO Arthritis or Rheumatism                   | YES NO Hepatitis                    | YES NO Thyroid problems                       |
| YES NO Rheumatic Fever                           | YES NO Hemopheliac                  | YES NO Headaches                              |
| YES NO Rheumatic Heart Disease                   | YES NO Fainting spells              | YES NO Temporal Mandibular Disorder (TMD/TMJ) |
| YES NO Heart Defect or Murmur                    | YES NO Seizures                     | YES NO Drug or Alcohol addiction              |
| YES NO Angina or Heart Attack                    | YES NO Anemia                       | YES NO Sexually transmitted disease           |
| YES NO Pacemaker                                 | YES NO Asthma                       | YES NO HIV or AIDS                            |
| YES NO Prosthetic Cardiac Valves                 | YES NO Glaucoma                     | YES NO Cancer or Tumor                        |
| YES NO Complex Cyanotic congenital heart disease | YES NO Stroke                       | YES NO Radiation treatment                    |
| YES NO Heart Surgery                             | YES NO Diabetes                     | YES NO Chemotherapy treatment                 |
| YES NO High Blood Pressure                       | YES NO Epilepsy                     | YES NO taken "Phen-Fen"                       |
| YES NO Pulmonary Shunts or conduits              | YES NO Tuberculosis                 | YES NO taken Redux                            |
| YES NO Mitral Valve Prolapse                     | YES NO Sinus trouble                | YES NO taken Cortisone                        |
| YES NO Leukemia                                  | YES NO Joint replacement or Implant | YES NO Latex Allergy                          |
|  | YES NO Kidney problems              |   |

42) Does your child have any other medical conditions we should be aware of? YES NO Explain: \_\_\_\_\_

43) For Females: A) Are you pregnant? YES NO C) Are you nursing? YES NO  
B) Months pregnant: \_\_\_\_\_ D) Are you taking birth-control pills? YES NO

44) This is to certify that I have read and understand the above information. I have completed the requested information and have verified that it is correct and truthful. I have disclosed all information regarding my insurance. I understand that if I am not covered or am ineligible for insurance coverage, I will be responsible for the outstanding portion of fees. I consent to use of the above information for office purposes. I understand that I am responsible for notifying Lakewood Cerritos Dental Centers if there are any changes to the above information. I authorize my child to be examined by Lakewood Cerritos Dental Centers.

45) Parent's Signature: X 46) Date:  / /

FOR OFFICE USE ONLY	I have reviewed this patient's information and medical history above.	FOR OFFICE USE ONLY
Doctor's Signature: _____	Date: <u> / /</u>	