WELCOME

Robert W. Cady, D.D.S.
1555 S. Washington
Saginaw, MI 48601
(517) 754-0219

1 ABOUT YOUR CHILD

Name: _____

Nickname: _____

Birthdate: _____ ☐ Male ☐ Female
Month Day Year

Social Security #: _____

Special interests, sports or hobbies: _____

_____

_____

Home Address: _____

_____
Apt./Condo # City State Zip Code

Home Phone: _____

Referred by: _____

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

2 ABOUT YOU

Your Name: _____

Social Security #: _____

Relationship to child: _____

Your home phone and address, if different from child's _____

Home phone _____

Address _____

_____
Apt./Condo # City State Zip Code

Occupation: _____

Employer: _____

Work phone: _____ Ext. _____

Beeper/Car phone: _____

3 DENTAL INSURANCE COMPANY

Primary Insurance

Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to child: _____

Insured's Social Security #: _____

Birthdate: _____

Employer: _____

Secondary Insurance

Insurance Co.: _____

Address: _____

Phone #: _____

Group #: _____

Insured's Name: _____

Relationship to child: _____

Insured's Social Security #: _____

Birthdate: _____

Employer: _____

4 DENTAL /MEDICAL HISTORY

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present? ☐ Yes ☐ No If yes, please explain: _____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Please rate your child's oral health. ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: _____

Phone #: _____

The approximate date of last visit: _____

Please rate your child's mental health. ☐ Good ☐ Fair ☐ Poor

Is your child allergic to any drugs? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? ☐ Yes ☐ No

5 Has your child ever had any of the following medical conditions or problems?

Please circle

Y N Heart Murmur

Y N Heart problems of any kind

Y N Convulsions/Epilepsy

Y N Cancer

Y N Diabetes

Y N Rheumatic Fever

Y N HIV/AIDS

Y N Hemophilia

Y N Bleeding problems of any kind

Y N Hearing Impairment

Y N Hyperactive

Y N Any Operations _____

Y N Any stays in hospital _____

Are there any medical conditions or problems relating to your child that need further explanation?

☐ Yes ☐ No

If yes, please list: _____

6 In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Phone: _____ Phone #2: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of Parent or Guardian _____ Date _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions, please feel free to ask us at any time.