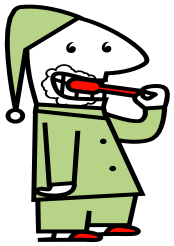
Caparelli & Mellis Family Dentistry



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date _____ ID#/SS#_____

Name of Child _____
Last Name First Name Initial Nickname

Address_____
Street City State Zip

Sex M__ F__ Age_____ Birthdate _____ Home phone ( )_____

Hobbies or Interest_____

Person financially responsible_____ Relationship to patient_____

Address_____
Street City State Zip

Home phone( )_____ Work phone( )_____ Cell phone( )_____

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household)

Name_____ Relationship_____ Hm# ( )_____ Wk# ( )_____

GUARANTOR and INSURANCE INFORMATION

Father's name/Guardian_____ Mother's name/Guardian_____

Address (If different from patient's)_____ Address(if different from patient)_____
Street Street

_____ _____
City State Zip City State Zip

Hm# ( )_____ Work # ( )_____ Hm# ( )_____ Work # ( )_____

Employer _____ Employer _____

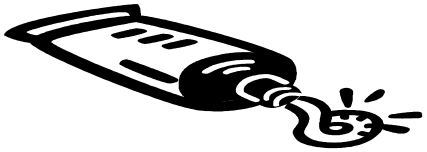
SS# ____-____-_____ Birthdate _____ SS# ____-____-_____ Birthdate _____

Insurance Co. _____ Insurance Co. _____

Group# _____ Group# _____

Assignment And Release: I, the undersigned certify that I (or my dependent) have insurance coverage with _____ And assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date



Dental History

Reason for today's visit_____ Former Dentist_____
Last dental visit_____ City/State_____
Date of last dental x-rays_____ How often does child brush teeth?_____
How often does child floss teeth?_____ Any unhappy dental experiences?_____

Place a mark on yes or no to indicate if child has had any of the following:

Bad Breath	□ yes □ no	Grinding teeth	□ yes □ no	Sensitivity to sweets	□ yes □ no
Bleeding gums	□ yes □ no	Gums swollen or tender	□ yes □ no	Sensitivity when biting	□ yes □ no
Blisters on lips or mouth	□ yes □ no	Jaw pain or tiredness	□ yes □ no	Sores or growths in mouth	□ yes □ no
Burning sensation on tongue	□ yes □ no	Lip or cheek biting	□ yes □ no	Thumb sucking or pacifier	□ yes □ no
Chew on one side of mouth	□ yes □ no	Loose teeth or broken fillings	□ yes □ no □		
Clicking or popping jaw	□ yes □ no	Mouth breathing	□ yes □ no		
Dry mouth	□ yes □ no	Mouth pain, brushing	□ yes □ no		
Fingernail biting	□ yes □ no	Orthodontic treatment	□ yes □ no		
Food collection between teeth	□ yes □ no	Pain around ear	□ yes □ no		
		Sensitivity to cold	□ yes □ no		
Foreign objects	□ yes □ no	Sensitivity to heat	□ yes □ no		

Health History

Physician's Name_____ Date of last visit_____

Place a mark on yes or no to indicate if child has had any of the following:

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
□	□	Abnormal Bleeding	□	□	Heart Murmur	□	□	Liver Disease
□	□	Alcohol Abuse	□	□	Emphysema	□	□	Low Blood Pressure
□	□	Allergies	□	□	Epilepsy	□	□	Mitral Valve Prolapse
□	□	Anemia	□	□	Fainting Spells	□	□	Pace Maker
□	□	Angina Pectoris	□	□	Fever Blisters	□	□	Pneumocystitis
□	□	Arthritis	□	□	Frequent Headaches	□	□	Psychiatric Problems
□	□	Artificial Bones	□	□	Glaucoma	□	□	Radiation Therapy
□	□	Artificial Heart Valve	□	□	Hay Fever	□	□	Rheumatic Fever
□	□	Asthma	□	□	Heart Attack	□	□	Seizures
□	□	Blood transfusion	□	□	Heart Surgery	□	□	Shingles
□	□	Cancer-Chemotherapy	□	□	Hemophilia	□	□	Sickle Cell Anemia
□	□	Colitis	□	□	Hepatitis A	□	□	Sinus Problems
□	□	Congenital Heart Defect	□	□	Hepatitis B	□	□	Stroke
□	□	Diabetes	□	□	High Blood Pressure	□	□	Thyroid Problems
□	□	Difficulty Breathing	□	□	Hiv + AIDS	□	□	Tuberculosis
□	□	Drug Abuse	□	□	Kidney Problems	□	□	Ulcers
						□	□	Venereal Disease
						□	□	Yellow Jaundice

Does child wear contact lenses? □ Yes □ No
Females: Are you pregnant? □ Yes □ No Due date_____
Taking birth control pills? □ Yes □No Are you nursing? □Yes □No

Medications

List any medications child is currently taking and the correlating diagnosis:_____
_____
_____
( ) Currently not taking medications(please check if applicable)
Pharmacy name:_____
Phone ( )_____

Allergies

□ Aspirin □ Local Anesthetic
□ Barbiturates (sleeping pills) □ Penicillin
□ Codeine □ Sulfa
□ Iodine □ Other _____
□ Latex □ None