MINOR DEPENDENT HEALTH HISTORY

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

CIRCLE

1. Is your child presently under the care of a physician (including routine checks)? .... Yes No
   Physician's Name ______________________________
   Address ______________________ Phone # ______________
2. Has your child/adolescent ever had any serious illness, accidents, or hospitalizations? .... Yes No
   If yes, please describe. ______________________________
3. Is he/she presently taking any medications? .... Yes No
   If yes, list medication and what condition it is treating. ______________________________

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4. Has he/she ever reacted adversely to any of the following medications? (circle) .... Yes No

Aspirin	Nitrous Oxide (laughing gas)	Local Anesthetic (Novocain or Xylocaine)
Darvon	Erythromycin	Fluoride
Codeine	Percodan	Valium
Demerol	Penicillin	Other: ______________

5. Circle any of the following which he or she has had or have at present:

Heart Murmur	Blood Transfusion	Retardation
Rheumatic Fever	Hepatitis A (infectious)	Hyperactivity
Prolapsed Mitral Valve	Hepatitis B (serum)	Learning Disability
Barlow's Syndrome	Liver Disease	Fainting/Dizzy Spells
Congenital Heart Problems	Ulcers	Psychiatric Treatment
Heart Surgery	Anorexia/Bulemia	Alcohol/Drug Dependency
Asthma	Diabetes	Veneral Disease
Respiratory Disease	Kidney Problems	Pregnancy
Tuberculosis	Thyroid Disease	Cosmetic Surgery
Anemia	Cancer/Malignancy	Sinus Trouble
Clotting Disorders	Arthritis	Allergies/Hives
Hemophilia	Cortisone Medications	Injury to Head or Neck
A.I.D.S.	Growth Disturbances	Ear Infections
ARC	Hearing Difficulties	Strep Throat
Sickle Cell Disease	Speech Difficulties	Tonsillitis

6. Does he/she use tobacco in any form? .... Yes No
7. Does your child/adolescent have any disease, condition or problem not listed? .... Yes No
   If yes, please describe. ______________________________

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8. Is there any other medical information that would be helpful to us in treating your child/adolescent? .... Yes No

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I AFFIRM THAT THE ABOVE INFORMATION IS TRUE

Parent/Guardian Signature ______________________________ Date ____/____/____

CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any treatment, medication or therapy that may be indicated, and further authorize and consent that Doctor choose and employ assistance as deemed fit. I understand that Doctor will discuss needed treatment with parent or guardian whenever possible, but I give my consent for treatment in the event of an emergency or in the event that I cannot be reached.

Parent/Guardian Signature ______________________ Date __________ Witness ______________

MINOR DEPENDENTS REGISTRATION

DATE: ____________

Patient's Name: ______________________________ Sex: M F Date of Birth: ____________

Address ____ City ______ State ______ Zip ______

Patient's Home Phone ____________ Patient's Work Phone ________________________

If Full Time Student, Please List School and City ______________________________

Parents or Guardians with whom Patient is Living:

Name ______________________ Relationship __________/Work Phone __________

Name ______________________ Relationship __________/Work Phone __________

Please list other members of your family who are patients in this office: ______________________

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Who referred you to us? ____

ACCOUNT INFORMATION

Who is responsible for this account (Guarantor*) *Guarantor is Parent or Guardian with whom minor resides. ________

Guarantor please read and sign: I understand that responsibility for payment for Dental Services provided in this office for my dependant is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1% finance charge (12% annually) may be added to any balance over 60 days old. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection and reasonable attorney fees as may be required to effect collection of this note. I understand that insurance companies normally pay within 3-4 weeks. This dental office will allow 60 days for insurance to pay its portion. If there is a balance after that time, it will be due in full. Guarantor's Signature:

____

INSURANCE INFORMATION:

I authorize release of information on dental claims to insurance companies ______________________
Signature

I assign payment of insurance benefits to Doug Booth, D.D.S., unless otherwise specified. ______________
Signature

A. Does Guarantor have dental insurance that covers this Patient? Yes ____ No____ If yes, please give name, address

and phone number of insurance company: ______________________________________

Employee Name: ______________ S.S. # ____________________ Employer: ______________

Employee's Date of Birth ______________ Relationship to this Patient ______________

Please List Group # ______________ Policy # ________ or other necessary information that will enable us

to help you with filing your insurance. ______________________________________

B. Is this Patient covered by a second dental insurance plan? Yes ____ No____ If yes, please give name, address and

phone number of insurance company: ______________________________________

Employee Name: ______________ S.S. # ____________________ Employer: ______________

Employee's Date of Birth ______________ Relationship to this Patient ______________

Please List Group # ______________ Policy # ________ or other necessary information that will enable us

to help you with filing your insurance. ______________________________________

MMP 830-1211 FORM NO. 225-89