

## **Child Information and Health History**

Patient Name		* * * * * * * * * * * * * * * * * * * *	Date of Birth					
(Last)	(MI)	(First)						
Nickname	_							
Fathers Name / Legal Guardian			Date of Birth					
Drivers License #	Social Sec	urity#						
Mailing Address		City	State Zip					
Residence Phone	Cell Phor	ne	<u> </u>					
Employer	-		Work Phone					
Mothers Name/ Legal Guardian			Date of Birth					
Drivers License #	Social Secu	rity #	Cell Phone					
Mailing Address		City	State Zip					
Residence Phone	Cell Ph	none						
Employer	1	Work Phone						
Emergency Contact Person	(Relationship)							
Primary Dental Insurance	(Relationsh	nip)						
Insured Person		<u> </u>	Date of Birth					
Insurance Company		Group #	ID#					
Secondary Dental Insurance								
Insured Person	4		Date of Birth					
Insurance Company	÷	Group #	ID#					
	Consent fo	r Dental Treatı	ment					
Р		full at the time of gements have been a						
co-payment and deductibles that my ins insurances at the time services are rend directly to the dentist of insurance benef	surance does not cover dered, I will be respons fits otherwise payable ency fees of 35%, incu	r. I also understand that sible for billing the secont to me. I understand that irred by me. I hereby at	vices rendered and also responsible for paying any tif I do not present both primary and secondary indury insurance. I hereby authorize payment t I am responsible for all costs of dental treatment, uthorize release of any information, including the ny.					
	my responsibility to infe	orm this office of any ch	dge. I also understand that this information will be langes in my medical status. I authorize the lary for proper dental care.					
Signature			Date					

1. Is your child allergic to anything? (medicine, food)	Patient's Name					D	ate of Birth
1. Is your child taking any medicines at this time? 2. Is your child ever been diagnosed and/or treated for his/her Heart? 3. Has your child ever heen diagnosed and/or treated for his/her Heart? 5. Is your child ever heen a Rheumatic Fever? 5. Is your child ever heen a patient in a hospital? 7. Has your child ever received general anesthesia? 8. When was your child's last dental visit? 9. Does your child's last dental visit? 9. Does your child's test brushed once daily? 10. Are your child's test brushed once daily? 11. What type of toothpasts does your child use? 12. At what age did your child stop bottle /breast feeding?  Organs and Systems Has this child ever been treated for any of the following? Please check yes or no: 12. At what age did your child stop bottle /breast feeding?  Organs and Systems Has this child ever been treated for any of the following? Please check yes or no: 12. At what age did your child stop bottle /breast feeding?  Organs and Systems Has this child ever been treated for any of the following? Please check yes or no: 13. Speech / Hearing 15. Speech / Hearing 16. Bones 17. Gastrointestinal (Stomach) 17. Gastrointestinal (Stomach) 18. Skin 19. Speech / Hearing 19. Speec	-Attent 5 Name						
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Eyes, Ears, Nose, Throat							
Illness   Has this child ever been diagnose as having any of the following conditions? Please check yes or no:		1000		y	adder		☐ ☐ Tonsils / Adenoids
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Yes       No       Yes       No       Yes       No       Onthopedic Problems       No Onth	Illness Has this child ever been diagnose as have	ing any of the	followi	ng co	nditions? Pleas	e check y	res or no:
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Anemia		The state of the s		Distu	rbance	-	
Allergy	☐ ☐ Anemia					22.2	
Asthma					dina Droblem	100000	
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## APPOINTMENT POLICY

We see patients on an appointment basis. Your appointment time is reserved exclusively for you. We respect your time and will make every effort to remain on schedule; therefore we ask that you please arrive on time for your appointment.

We understand that circumstances arise that prevents patients from keeping appointments. If you are not able to keep an appointment, please give us a call 24 hours in advance. (exception may be made in an emergency). With this notice we can reschedule your appointment for the near future.

We request this courtesy as it allows us to see our patients promptly.

Our policy states that once the 2<sup>nd</sup> scheduled appointment is missed, a notice will be sent alerting of the consequence of missing the 3<sup>rd</sup> scheduled appointment within a 12 month period. That consequence is that the patient will be allowed emergency care only. This is defined as a probationary period and will be in effect for 12 months.

## Appointment failure is defined as:

- 1. Any appointment for which the patient does not arrive and notify the clinic at least 24 hours in advance
- 2. A patient that arrives 15 minutes into the appointment

I have read and understand the above appointment policy for Legends Dental.