Michael P. Bryan, DDS
A Family Dental Practice

THE BENEFITS OF A HEALTHY SMILE ARE IMMEASUREABLE! PLEASE FILL OUT THIS FORM COMPLETELY. THE BETTER WE COMMUNICATE THE BETTER WE CAN CARE FOR YOU!

TELL US ABOUT YOUR CHILD

NAME____ **I prefer to be called**____________________
LAST FIRST MIDDLE

BIRTHDAY____________ **HOBBIES**________________________ **MALE** ☐ **FEMALE** ☐

WHOM MAY WE THANK FOR REFERING YOU? ____

OTHER FAMILY MEMBERS BEING SEEN BY US? ____

PERSON RESPONSIBLE FOR ACCOUNT

NAME(LAST, FIRST, MI)______________________________ **BIRTHDATE**____________________

ADDRESS____
STREET CITY STATE ZIPCODE

SOCIAL SECURITY #________________ __**CA D.L#**______________ **MALE** ☐ **FEMALE** ☐

E-MAIL ADDRESS____

HOME PHONE_________________ **CELL PHONE**________________ **WORK PHONE**_______________

EMPLOYER____
ADDRESS

INSURANCE INFORMATION

PRIMARY

INSURED NAME______________________________________ **SS#**__________________________

INSURED EMPLOYER__________________________ **INSURED BIRTHDATE**______________________

INSURANCE CO. NAME_________________________________ **PHONE #**______________________

ADDRESS_________________________________ **GROUP #**(ID, LOCAL, POLICY#)__________________

SECONDARY

INSURED NAME______________________________________ **SS#**__________________________

INSURED EMPLOYER__________________________ **INSURED BIRTHDATE**______________________

INSURANCE CO. NAME_________________________________ **PHONE #**______________________

ADDRESS_________________________________ **GROUP #**(ID, LOCAL, POLICY#)__________________

GETTING TO KNOW YOUR CHILD

1. Name of previous Dentist________________________ Last visit _____________________ Last X-rays____________________
2 Has your child seen a dentist before? __________________________. ____
3. Have your child or anyone in your family has difficulty with anesthesia? ____
4. Is your child nervous about, or had an unfavorable experience regarding dental treatment? ___________________________
5. Has your child ever had to use Antibiotics before a dental procedure? ____
6. Has there been any injury to face, mouth, teeth of chin? ____
7. Does your child brush their teeth at least twice a day? ____
8. Does your child Floss daily? ____
9. Do you watch the amount of soda and sugary snacks? ____
12. Is he/she having any pain, or a problem which concerns you? ____
13. Name and address of physician____Phone#______________________

HEALTH HISTORY

Does or has your child have any of the following? Please Circle

Heart Disease	Heart Murmur	Heart Surgery	Mitral Valve prolapsed
Epilepsy, Seizures, Convulsions	Diabetes	Hemophilia	Cold Sores or Fever Blisters
Aids/HIV Positive	Kidney/Liver Disease	Rheumatic / Scarlet Fever	Handicaps/Disabilities
Asthma	Hemophilia	Hepatitis A,B, C or other	Cancer
Allergy to Latex or plastics	Hearing impairment	Arthritis	Surgery

55. Please discuss any medical problems that your child has/had?
____

56. Is he/she allergic to any medications, foods?
____

57. Does your child have any of the following habits?

Clenching or Grinding teeth	Thumb or Finger sucking,	Mouth Breather
Nail biting	Nursing or Bottle Habits	Speech Problems

List Current Medications/ Supplements your child is taking:
____

____

CONSENT

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner, and have answered all questions to the best of my knowledge. If there are ever have any changes I will inform you at the next appointment.

I hereby authorize release of any information needed an also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I UNDERSTAND THERE MAY BE A CHARGE FOR ANY MISSED APPOINTMENTS NOT CANCELLED 48 HOURS BEFORE THE APPOITMENT TIME.

Patient Signature: ____Date:__________________________