

**Northern Dental Specialists**

**Dr. Lawrence Brown**

Child's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Father's Address \_\_\_\_\_  
Father's Occupation \_\_\_\_\_ Name of Employer \_\_\_\_\_  
Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mother's Address \_\_\_\_\_  
Mother's Occupation \_\_\_\_\_ Name of Employer \_\_\_\_\_  
Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Do Mother, Father, and Child All Live Together? Yes \_\_\_ No \_\_\_  
If No, Who is responsible for this account? Mother \_\_\_ Father \_\_\_ Other \_\_\_  
If Other, Name \_\_\_\_\_ Address \_\_\_\_\_

Do You Have Dental Insurance? Yes \_\_\_ No \_\_\_ Insurance Company? \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Is Child Covered By Welfare? Yes \_\_\_ No \_\_\_ *Please Note: Welfare card MUST be presented at each appointment.*

**DENTAL HISTORY**

Is This ? (indicate Yes or No) First Dental Visit \_\_\_\_\_ An Emergency \_\_\_\_\_  
Specific Dental Problems That Concern You \_\_\_\_\_  
Is there now or has there been any of the following: (circle) Cavities Pain Fillings Gum infection  
Broken tooth Extracted tooth Other \_\_\_\_\_

**MEDICAL HISTORY**

Name of Physician \_\_\_\_\_ Office Phone # \_\_\_\_\_  
Is child: under care of physician now? \_\_\_ Reason \_\_\_\_\_  
Taking Medication? \_\_\_ Name & dosage \_\_\_\_\_  
Allergic to any medicine(s) or anything else: List \_\_\_\_\_  
Has Child Had A History of : (circle) Asthma Anemia Convulsions Diabetes Emotional Problems  
Excessive Bleeding Hearing Problems Heart Trouble Kidney Disease Liver Disease  
Mental Disturbance Rheumatic Fever Speech Impediment Surgery Blood Transfusion  
Any Special Problems Not Listed  
Above? \_\_\_\_\_

**SOCIAL HISTORY**

Date of Birth \_\_\_/\_\_\_/\_\_\_ Name of School \_\_\_\_\_ Grade \_\_\_\_\_  
Name(s) and Age(s) of Siblings \_\_\_\_\_  
Child's Hobbies or Other Interest \_\_\_\_\_

Whom May We Thank For Referring You To Our Office? \_\_\_\_\_

**PERMISSION**

I (we) hereby give authorization as a parent /guardian to Lawrence E. Brown, D.D.S. for the completion of all agreed upon dental services for my child, and agree to be personally responsible for such financial obligations. Our policy is for payment to be made at the time of service. We will be happy to assist you in filing your insurance claim to expedite your reimbursement.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_