Jamie Diament-Golub, D.M.D. and Elizabeth Simon D.D.S. & Associates

Child's Name _____M/F Birth Date _____
First MI Last
Address_____Town_____Zip_____Ph#_____

Parent 1_____ Soc Sec #_____Cell #_____
Occupation_____Employer_____Work Phone_____
E-mail_____@_____

Parent 2_____Soc Sec #_____Cell #_____
Occupation_____Employer_____Work Phone_____
E-mail_____@_____

I will be paying for my first visit with : Cash ___Check___Credit Card_____

Whom may we thank for referring you? _____
Names and ages of other children_____
Family Dentist_____Child's Physician_____Phone #_____
Name of medications taken recently by your child (including vitamins)_____
Has your child had any type of allergic reaction to any food, medicine, or other substances? Please describe below
_____

Has your child ever been hospitalized?_____If yes, give details_____
Does your child have a heart murmur or heart defect**?**_____If yes, give details_____
If the patient has had any of the following diseases or conditions, please check one(s):

__Measles	__Diabetes	__Bleeding Problems	__AIDS/AIDS related complex
__Chicken Pox	__German or "3 day" Measles	__Asthma or Wheezing	__Skin Problems
__Mumps	__Hearing Difficulties	__Rheumatic Fever	__Bone/Joint Problems
__Scarlet Fever	__Speech Difficulties	__Kidney Disease	__Growth Abnormalities
__Pneumonia	__Emotional Difficulties	__Tuberculosis	__Whooping Cough
__Birth Defects	__Fainting or Dizziness	__Epilepsy/Seizures	__Broken Bones
__Poor Vision	__Sickle Cell Anemia	__Serious Accidents	__Liver Disease/Hepatitis
__Anemia	__Removal of Tonsils or Adenoids	__Cancer	

____THERE IS NO HISTORY OF THESE PROBLEMS

Does your child have any of the following? __Autism __ADD __PDD
What is your main reason for bringing your child today?_____
Is this the child's first dental visit?_____If not, when was the last visit and for what reason?_____
Were dental x-ray films ever taken of your child?_____By whom?_____
Does your child have any of the following habits?

__Thumb Sucking	__Mouth Breathing	__Speech Problems	__Pacifier
__Using the bottle	__Tongue Thrusting	__Grinding of the teeth	

Has your child ever had any injury to the face or teeth?_____
Has your child ever had an unfavorable reaction to local OR general anesthesia?_____

I give my consent for general dental treatment by Jamie Diament-Golub, D.M.D. and Dr. Elizabeth Simon D.D.S. & Assoc. Furthermore, the undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

X_____ _____
Signature Date Print Name Relationship To Child