Robert F. Sonntag, D.D.S.

ABOUT YOUR CHILD:

Name _____ Nickname _____

Home Address _____City _____ State _____ Zip _____

Home/Cell Phone _____ Email _____

Birthdate _____ ☐ Male ☐ Female SS # _____

Special interests, sports or hobbies _____

_____

Referred by _____

_____

ABOUT YOU:

Name _____Relationship to child _____

Your Address (if different from child's) _____

Your Phone (if different from child's) _____SS# _____

Occupation _____ Employer _____

Work Phone _____ext. _____ Pager / Other _____

PRIMARY DENTAL INSURANCE

Insurance Co. name _____

Address _____

Phone # _____ Group plan or policy # _____

Policy holder's name _____ Policy holder's birthday _____

Policy holder's SS # _____ Policy holder's employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. name _____

Address _____

Phone # _____ Group plan or policy # _____

Policy holder's name _____ Policy holder's birthday _____

Policy holder's SS # _____ Policy holder's employer _____

see other side

GENERAL INFORMATION

Has your child been to the dentist before? ☐ Yes ☐ No *If yes, date of last appointment* _____

Are there any dental problems that you are aware of at present? _____

_____

GENERAL INFORMATION

Is your child currently under the care of a physician? ☐ Yes ☐ No *If yes, please explain:* _____

_____

Child's Physician _____ Phone# _____

The approximate date of last visit _____

Is your child allergic to any drugs? ☐ Yes ☐ No *If yes, please list:* _____

_____

Is your child taking any prescription/over-the counter drugs? ☐ Yes ☐ No *If yes, please list:* _____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS OR PROBLEMS?

Heart Murmur/Mitral Valve Prolapse	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No
Convulsions/Epilepsy	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Hemophilia/Blood Transfusion	☐ Yes ☐ No
Bleeding Problems	☐ Yes ☐ No	Hearing Impairments	☐ Yes ☐ No
Hyperactive	☐ Yes ☐ No	Any Operations	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No

If there have been operations or recent hospitalizations for any reason, please explain: _____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need. **The Parent or Guardian who accompanies the child is responsible for payment at the time of service. I understand I am responsible for payment regardless of insurance coverage.**

Signature _____ Date _____