Welcome!

Dr. Michael Casey + Dr. Mary Lenz

Family Dentistry

To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ DOB (MM/DD/YY): _____

Nick Name: _____ Age: _____ Social Security #: _____

Home Address: _____

City, State, Zip: _____ Phone Number: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ Relationship: _____

DOB (MM/DD/YY): _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ Relationship: _____

DOB (MM/DD/YY): _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____

Relationship to Patient: _____ DOB (MM/DD/YY): _____ Social Security #: _____

Employer: _____ Subscriber's ID: _____ Group #: _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____

Relationship to Patient: _____ DOB (MM/DD/YY): _____ Social Security #: _____

Employer: _____ Subscriber's ID: _____ Group #: _____

Child's Name

MEDICAL HISTORY

Child's Physician: _____ City: _____

Phone: _____ Date Last Seen: _____

Is your child presently under the care of a physician for any medical issue? ☐ Yes ☐ No

If yes, please describe: _____

Is your child currently taking medication? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been hospitalized for surgery? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have allergies to any food or medication? ☐ Yes ☐ No

If yes, please describe: _____

Is your child pregnant? ☐ Yes ☐ No

Does your child have a history of:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmurs	☐	☐	Diabetes	☐	☐	Hearing Impairment	☐	☐	Cancer/Tumors
☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Speech Problem	☐	☐	Chemo/Radiation Therapy
☐	☐	Allergies	☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Leukemia
☐	☐	Allergy or Sensitivity to Anesthesia	☐	☐	Seizures/Convulsions	☐	☐	ADD/ADHD	☐	☐	Hepatitis
☐	☐	Drug Sensitivities	☐	☐	Recurrent Headaches	☐	☐	Autism/Asperger's	☐	☐	Bleeding Problems
☐	☐	High Temperature	☐	☐	Fractures Jaw	☐	☐	AIDS/ARC/HIV	☐	☐	Blood Disorders
☐	☐	Brain Injury/Concussion	☐	☐	Lung Problems	☐	☐	Kidney/Liver Involvement	☐	☐	High Blood Pressure
☐	☐	Vision Problems	☐	☐	Artificial Prosthesis	☐	☐	Nervous System Issues	☐	☐	History of Blood Transfusion
☐	☐	Premature Birth	☐	☐	Congenital Birth Defects				If yes, date of transfusion: _____		

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know? ☐ Yes ☐ No

If yes, please describe: _____

_____

I understand that the information I have given today is correct and the best of my knowledge.

_____ _____ _____

Signature Print Name Date

_____ _____ _____

Signature Print Name Date

_____ _____ _____

Signature Print Name Date