



Dr. Becky Maher
Healthy Smiles for a Lifetime!

Confidential Responsible Party Information

Responsible Party Name _____ Marital Status _____
Last First MI
Address _____ # of Yrs. _____ Own/Rent
Street City St. Zip
Previous Address _____
(if less than 3 yrs.) Street City St. Zip
Home Phone _____ Cell _____ Work _____ Relationship to Patient:
Mother ___ Father ___ Stepmom ___ Stepdad ___
E-mail _____ DOB: _____ SS#: _____
Employer _____ Occupation _____ # of Yrs. _____
Spouse's Name _____ Relationship to Patient:
Last First Mother ___ Father ___ Stepmom ___ Stepdad ___
Employer _____ Occupation _____ # of Yrs. _____
Cell Phone _____ Wk Phone _____ DOB: _____ SS#: _____

Confidential Patient Information

Name _____ M / F Birthdate _____
Last First MI
Address _____
Street City St. Zip
Home Phone _____ E-mail _____ SS#: _____
If patient is a minor, give parent's or guardian's name _____
Who may we thank for referring you to our office _____

Dental Insurance Information

Primary Insurance Co. _____ Phone # _____
Policy Holder's Name _____ ID/SS# _____ DOB: _____
Employer _____ GR# _____ Union Local# _____
Secondary Insurance Co. _____ Phone # _____
Policy Holder's Name _____ ID/SS# _____ DOB: _____
Employer _____ GR# _____ Union Local# _____

over...

Emergency Information

Emergency contact name _____

Complete address _____

Phone number _____ Relationship to Patient _____

General Information

General Dentist _____ Last Dental Visit _____ Other Family Treated @ VO _____

School _____ Hobbies _____

Siblings and their ages _____

Medical History

Physician _____ Last Visit _____ Phone # _____

Is the child currently under the care of a physician? Yes No If Yes, explain _____

Has the patient reached puberty or menstruation? Yes No

Have Tonsils or Adenoids been removed Yes No

Has the patient ever experienced jaw joint pain/discomfort (TMJ/TMD)? Yes No

Does the patient have any missing or extra permanent teeth? Yes No

Has the patient ever had an injury to: (select all that apply) Teeth Mouth Chin

Does/Has the patient ever had any of the following habits? Lip sucking/biting Nail biting Mouth breather

Prolonged bottle/pacifier Clenching/Grinding teeth Tongue thrusting Thumb/finger Sucking

Does the patient have speech problems? Yes No If yes, explain _____

Has the patient ever been evaluated for orthodontic treatment? _____

What are the main concerns that you would like to accomplish? _____

List all allergies or sensitivities _____

List all medications the patient is currently taking:

List any serious medical conditions treated for:

Special needs: _____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status.

I hereby authorize the release of any information for the purpose of insurance processing and dental diagnosing by the doctor.

I understand that where appropriate, credit bureau reports will be obtained.

Parent/Guardian signature _____ Date _____

This information has been updated by _____

Initial

Date