

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	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>	Chemo/Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Allergy or Sensitivity to Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Drug Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Autism/Asperger's	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems
<input type="checkbox"/>	<input type="checkbox"/>	High Temperature	<input type="checkbox"/>	<input type="checkbox"/>	Fractures Jaw	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Involvement	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Issues	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>	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 _____