Wright Smiles Pediatric Dentistry

Date ________________

Patient Updated Information

Name: ______________________ Preferred Name: ______________________

Birth date: ______________ Age: ________ Social Security #: ______________

☐ Male ☐ Female Hobbies: ______________________

Home Address: ______________________ Home Phone #: ______________

City: ______________ State: ________ Zip: ______________

Account Email Address: ______________________

Mother's Name: ______________________ Birth Date: ______________

Social Security #: ______________ Work Phone #: ______________ Cell Phone #: ______________

Father's Name: ______________________ Birth Date: ______________

Social Security #: ______________ Work Phone #: ______________ Cell Phone #: ______________

Dental Insurance Information

Policy Holders Name: ______________________ Birth Date: ______________

Social Security #: ______________________ Employer: ______________

Insurance Name & Phone #: ______________________ Id #: ______________

Has this patient had ANY history of difficulty with ANY of the following ? If YES, please check.

☐ AIDS/HIV
☐ ADD/ADHD
☐ Anemia/Blood Disorders
☐ Asthma
☐ Autism
☐ Behavioral/Sensory Issues
☐ Birth Defects
☐ Bladder Problems
☐ Cancer
☐ Cerebral Palsy
☐ Chicken Pox
☐ Diabetes
☐ Epilepsy/Seizure's
☐ Hearing Impaired
☐ Heart Disease/Heart Murmur
☐ Hepatitis
☐ Kidney Disease
☐ Liver Disease
☐ Measles/Mumps
☐ Rheumatic Fever
☐ Sickle Cell Disease/Trait
☐ Sinus Problems
☐ Thyroid Disease
☐ Tuberculosis
☐ Other: ______________

Allergies: ______________________

Medications: ______________________

Emergency Contact

In the event of an emergency, please list contact NOT living with you:

Name: ______________ Relationship: ______________ #: ______________

Name: ______________ Relationship: ______________ #: ______________

I, being the parent or guardian of______________do hereby confirm that all above information is accurate and up to date. I fully understand that it is my responsibility to submit in writing to Wright Smiles Pediatric Dentistry if such above information changes. I request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and Fluoride, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Responsible Party: ______________________ Date: _____ /_____ /________