ACCOUNT NO. ____________

Date ____________
Home Phone # ____________
M. Work # ____________
F. Work # ____________
Mobile # ____________
Pager # ____________
(Circle One) Male Female

MICHAEL L. GORDON, D.M.D.
DENTISTRY FOR CHILDREN

These Questions Are Of Great Value In Aiding Us
To A Better Understanding Of Your Child

Patient's Name ____________ Birthdate ____________ Age ____________
Home Address ____________ City, State, Zip ____________
E-Mail Address ____________
Attends What School ____________
Name and Age Of Brothers ____________
Name and Age Of Sisters ____________
Patient's Physician Or Pediatrician ____________ Phone # ____________
Family Dentist ____________ Phone # ____________
Who May We Thank For Referring You To Us ____________
Address ____________

RESPONSIBLE PARTY INFORMATION

Name ____________ Marital Status ____________
Residence Address ____________
Mailing Address ____________
How Long At This Address ____________
Home Phone # ____________ Work Phone # ____________ Cell Phone # ____________
Previous Address (if less than 3 years) ____________
Social Security # ____________ Birthdate ____________ Relationship To Patient ____________
Employer ____________ Occupation ____________ No. of Years Employed ____________
Spouse/Parent's Name ____________
Residence Address (if different) ____________
Mailing Address (if different) ____________
Home Phone # ____________ Work Phone # ____________ Cell Phone # ____________
Social Security # ____________ Birthdate ____________ Relationship To Patient ____________
Employer ____________ Occupation ____________ No. of Years Employed ____________

INSURANCE INFORMATION

Insured's Name ____________ Social Security # ____________
Insurance Company ____________ Group # ____________ Local # ____________
Insurance Company Address ____________ Toll Free # ____________
If You Have Dual Insurance:
Insured's Name ____________ Social Security # ____________
Insurance Company ____________ Group # ____________ Local # ____________
Insurance Company Address ____________ Toll Free # ____________

EMERGENCY INFORMATION

Name Of Nearest Relative Not Living With You ____________
Complete Address ____________
Home Phone # ____________ Work Phone # ____________

MEDICAL HISTORY

Please Respond To Every Question

		YES	NO
1.	Has Your Child Ever Had:		
	a. Frequent Nose Bleeds?	☐	☐
	b. Easy Bruising?	☐	☐
	c. Frequency Of Urination?	☐	☐
	d. Prolonged Bleeding When Cut?	☐	☐
	e. Frequent Colds?	☐	☐
	f. Bleeding Gums?	☐	☐
2.	Has Your Child Ever Been Hospitalized Or Been In A Hospital Emergency Room?	☐	☐
	If Yes, Why? ____________		
	How Long Ago? ____________		
3.	Is Your Child Now Under The Care Of A Physician?	☐	☐
	If Yes, Why? ____________		

(OVER)

		YES	NO
4.	Is Your Child Taking Any Medications? If Yes, What? ______	☐	☐
5.	Is Your Child Allergic To Anything? What? ______	☐	☐
6.	Has Your Child Ever Had A Reaction To Latex, Penicillin Or Any Other Drugs? What? ______	☐	☐

Does **Your Child** Now Have Or Has He/She Ever Had Any Of The Following?

		YES	NO
1.	Rheumatic Fever	☐	☐
2.	Heart Disease	☐	☐
3.	Heart Murmur	☐	☐
4.	Liver Disease	☐	☐
5.	Kidney Disease	☐	☐
6.	Bladder Infections	☐	☐
7.	Respiratory Disease	☐	☐
8.	Asthma .... How Often? ______	☐	☐
9.	Has Any Member of Immediate Household Tested Positively For Tuberculosis? Who? ______		
10.	Pneumonia	☐	☐
11.	Anemia	☐	☐
12.	Sickle Cell Disease Or Trait	☐	☐
13.	Blood Disorders	☐	☐
14.	Has your **CHILD** ever been diagnosed with: (check all that apply) Brain Damage ☐ Depression ☐ Autism ☐ Bi-Polar ☐ Sensory Disorder ☐		
15.	Mental Retardation	☐	☐
16.	Cerebral Palsey	☐	☐
17.	Hepatitis	☐	☐
18.	Diabetes	☐	☐
19.	Epilepsy	☐	☐
20.	Birth Defects, Please Specify	☐	☐
21.	Cancer	☐	☐
22.	Has Any Family Member Had Aids, HIV or Arc? .... Who? ______	☐	☐
23.	Has Any Family Member Had A Positive Blood Test for Aids Antibody, HIV or Arc? Who? ______	☐	☐
24.	Has Your Child Any History Of Thumbsucking, Fingersucking, Lip Biting, Nail Biting? (If Yes, Circle The Condition)	☐	☐
25.	Has Your Child Had Any Unfavorable Experience In A Dental Or Medical Office? (If Yes, Please Circle)	☐	☐
26.	Do You Consider Your Child To Be High Strung Or Generally Nervous?	☐	☐
27.	Has Your Child Had A Toothache Recently? Where? ______	☐	☐
28.	Give Date Of Last Dental Care? ______ Where? ______		
29.	**Has Any Blood Relative Had A Reaction To Local Or General Anesthesia?** Who? ______ Please Describe: ______	☐	☐

If You Have Previously Completed This Form For Another Child, Please Give That Child's Name

______

Because Your Child Is A Minor, It Becomes Necessary That A Signed Permission Is Obtained From A Parent Or Guardian Before Any/And All Necessary Dental Service Can Be Started And Accomplished By Dr. Gordon.

Authorization Is Hereby Granted As Such. Furthermore, I Will Be Responsible For Any Bill Incurred On This Child For Dental Treatment. I Understand That Where Appropriate, Credit Bureau Reports May Be Obtained.

X Date ______ **X** Signed ______

I Am (Check One Or More) ☐ **Legal Guardian** ☐ **Parent/Guardian** ☐ **Foster Parent** ☐ **Grandparent/Guardian** ☐ **Other**

I Hereby Authorize Payment of Insurance Benefits Directly To Dr. Michael L. Gordon, D.M.D. Inc.

X Signed ______

I Hereby Authorize Dr. Gordon To Release Any Required Information Or Xrays To Insurance Companies And Other Healthcare Professionals And To Share Medical Information And Other Information Needed To Process Insurance Claims And Meet My Child's Healthcare Needs.

I Authorize Dr. Gordon To Obtain Medical Information About My Child Including Medical, Dental And/Or Hospital Histories/Records.

X Signed ______

PLEASE SIGN IN ALL THREE PLACES INDICATED ABOVE
In The Future, Please Notify This Office Of Any Changes In Medical History