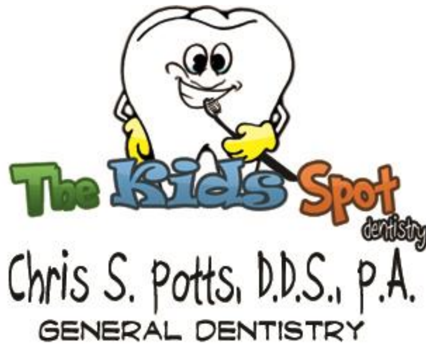

6008 Summerfield Drive
Texarkana, TX 75503

Office: (903)-223-7768

Demographic Information

Patient____Today's Date________________________

Name child would like to be called ____________________ Home Phone _______________________________

Birthday ________________________ Age________ Sex________ Child's SSN________________________

Home Address _____ ___________________________City__________________State________Zip__________

School ____Grade _____________________

Names & ages of other children in family ____

Parent/Guardian ______________________ Cell Phone ________________ E-mail ______________________

Employer ______________________ Work Phone ________________ SSN_______________DOB_________

Parent/Guardian ______________________ Cell Phone __________________ E-mail ___________________

Employer ______________________ Work Phone ________________ SSN_______________DOB_________

Who has legal custody of patient? ___________________________ Dental Insurance ☐ Yes ☐ No

Dental Insurance Company _______________________________ Group # _____________________________

Name of Insurance Subscriber _____________________________ SSN _______________ DOB _____

Whom may we thank for referring you to us? ____

What is the reason of your child's dental visit? ____

Health History

Is your child in good health? Name of the child's physician ____

Date of last physical exam ____

Has your child ever had a health problem? ____

Has your child ever been hospitalized? Please give reason and dates ___________________________________

____

Is your child allergic to anything? ____

Is your child currently taking any medications? Please give medication, dose, and reason _____________________