Lancaster Children's Dental
"Kids Love Us. Parents Trust Us"

1629 West Avenue J, Suite #104, Lancaster, CA 93534 • Telephone: (661) 945-0701

Referred _____

Father's Information:

Last Name	First Name	Home Phone #
Mailing Address		Alternate Phone #
City	State	Zip Code
Social Security #	Birth Date	Drivers' License #
Occupation/Employer		Spouse's Name

Mother's Information:

Last Name	First Name	Home Phone #
Mailing Address		Alternate Phone #
City	State	Zip Code
Social Security #	Birth Date	Drivers' License #
Occupation/Employer		Spouse's Name

Patient's Information:

Last Name	First Name	Birth Date	M/F
Hobbies		Pets	
Names of Brothers and Sisters			
Emergency Contact		Phone	

Primary Insurance

Name of Insured	SS#	Birth Date
Insurance Company		

Secondary Insurance

Name of Insured	SS#	Birth Date
Insurance Company		

Child's Physician _____

Is your child taking any prescribed medications? ❑ Yes ❑ No

If so, what kind and why? _____

_____

_____

If your child has had any of the following, please check box:

❑ Heart Disease
❑ Rheumatic Fever
❑ Heart Murmur
❑ Kidney Disease
❑ Liver Disease
❑ Bleeding Disorders
❑ Sickle Cell Anemia
❑ Epilepsy
❑ Nervous Disorders
❑ Hepatitis
❑ Cerebral Palsy
❑ Lung Disease
❑ Asthma
❑ Diabetes
❑ Hyperactivity
❑ Cleft Palate
❑ Autism
❑ Down's Syndrome
❑ Seizures

Developmental Problems Which affect:

❑ Speech
❑ Hearing
❑ Sight
❑ Physical Ability
❑ Mental Ability

OTHER HEALTH PROBLEMS (please explain): _____

_____

_____

Does your child have any allergies or had any unfavorable reaction to drugs? ❑ Yes ❑ No

Is your child taking Fluoride? Tablets / Drops ❑ Yes ❑ No Rinse ❑ Yes ❑ No

Remarks: _____

_____

_____

_____

_____

_____

_____

Permit for Dental Services Upon a Minor

I. I understand that I will be informed of all services before any treatment is rendered.

II. I do also authorize and request the administration of such anesthetics, medications, x-rays and/or sedatives as may be deemed advisable by Dr. Tran.

III. I, being the parent or legal guardian of _____ do hereby authorize and request the performance of dental services upon the person of this patient, and permit Dr. Tran and any staff under her supervision to perform whatever procedures that Dr. Tran judges to be dictated during treatment.

IV. I understand that I am financially responsible for all treatment provided, and a credit report may be obtained where necessary.

Signed _____ Date _____ Relationship _____