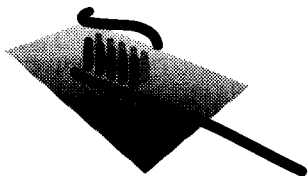


MONONA DENTAL, S.C.

RICHARD H. TETEAQ, D.D.S.



DATE _____

CHILD'S NAME _____ AGE _____ DATE OF BIRTH _____
LAST FIRST NICKNAME

RESIDENCE ADDRESS _____ CHILD'S SEX _____ GRADE _____

CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ MOTHER'S NAME _____
Last First Last First

FATHER'S ADDRESS _____ MOTHER'S ADDRESS _____

FATHER EMPLOYED BY _____ HOW LONG _____ HOME PHONE _____ BUS PHONE _____

MOTHER EMPLOYED BY _____ HOW LONG _____ HOME PHONE _____ BUS PHONE _____

PARENT'S SOCIAL SECURITY NUMBER (FATHER) _____ (MOTHER) _____

OTHER FAMILY MEMBERS THAT COME HERE: _____

FIRST NAME _____ LAST NAME _____

WHOM MAY WE THANK FOR REFERRING _____

DENTAL HISTORY

				YES	NO
Date of last visit to a dentist _____		Does your child brush teeth daily _____		<input type="checkbox"/>	<input type="checkbox"/>
For what service _____		Do you assist child with tooth brushing _____		<input type="checkbox"/>	<input type="checkbox"/>
_____	YES NO	How often _____		<input type="checkbox"/>	<input type="checkbox"/>
Has child complained about dental problems _____	<input type="checkbox"/> <input type="checkbox"/>	Is dental floss used _____		<input type="checkbox"/>	<input type="checkbox"/>
_____		How often _____		<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental experiences _____	<input type="checkbox"/> <input type="checkbox"/>	Are disclosing tablets used _____		<input type="checkbox"/>	<input type="checkbox"/>
_____		Is flouride taken in any form _____		<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth-teeth-head _____	<input type="checkbox"/> <input type="checkbox"/>	_____			
_____		Child's attitude to dentistry _____		<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifer, etc. _____	<input type="checkbox"/> <input type="checkbox"/>	_____			
_____		Do you desire complete dental service for the child _____		<input type="checkbox"/>	<input type="checkbox"/>
Any unusual speech habits _____	<input type="checkbox"/> <input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

Has the child ever had the following medical problems?

Please indicate any history of the following and write in details (dates, etc.) below:

Y N Heart Murmur	Y N Hemophilia	Y N Congenital Heart Defect	Y N Any stays in the hospital
Y N Cancer	Y N Asthma	Y N Convulsions/Epilepsy	Y N Kidney/Liver Problems
Y N Diabetes	Y N Hepatitis	Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Rheumatic Fever	Y N Tuberculosis	Y N Hearing Impairment	Y N Allergies
Y N HIV+/AIDS	Y N Anemia	Y N Any Operations	Y N Other _____
Y N Physical or psychological development delay.			

Please discuss any medical problems the child has had: _____

Child's Physician: _____ Phone #: _____ Last Visit Date: _____

Any current complaints? _____

Please list all drugs the child is currently taking: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date _____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

INSURANCE INFORMATION

DENTAL INSURANCE PLAN ONE

DENTAL INSURANCE PLAN TWO

INSURANCE COMPANY NAME _____

INSURANCE COMPANY NAME _____

ADDRESS:

ADDRESS:

CITY:

CITY:

STATE AND ZIP CODE:

STATE AND ZIP CODE:

GROUP ID:

GROUP ID:

- EMPLOYEE INFORMATION -

- EMPLOYEE INFORMATION -

RELATION TO INSURED:

RELATION TO INSURED:

INSUREDS NAME:

INSUREDS NAME:

ADDRESS

ADDRESS:

CITY:

CITY:

STATE:

STATE:

ZIP CODE:

ZIP CODE:

PHONE:

PHONE:

SUBSCRIBER ID:

SUBSCRIBER ID:

INSUREDS BIRTH DATE:

INSUREDS BIRTH DATE:

OFFICE POLICY

Payment is expected the day of the appointment. We offer a 5% discount for payments made in full. We honor MasterCard and Visa.

Payment arrangements are available for treatment plans over \$200.00.

INSURANCE:

In most cases, insurance does not cover the full cost of services. It is designed to reduce your cost, but not to eliminate it completely. Our staff will help you receive the maximum benefit available under your policy. However, please remember you are fully responsible for all fees charged by this office regardless of insurance coverage.

I have read and hereby agree that I am ultimately responsible for payment of this account.

Signature of Parent or Guardian