Patients under the age of 18
PLEASE COMPLETE THIS INFORMATION FOR OUR RECORDS

DAVID LESTER D.D.S.

Child's Name**:** ____
Last **First** **Middle**

Date of Birth: ________________________________

Residence Address: ____

City: ____ **State:** _______________ **Zip:** ________________

Parent or Guardian: ____

Best Phone Number to reach you regarding this patient: ____

Your Email: ____

How would you prefer that we contact you regarding this patient? VOICEMAIL EMAIL TEXT

IF APPLICABLE:

Dental Insurance Company: ____

Subscriber Name: ____ **D.O.B** ________________________

Subscriber Social Security Number: ____

Insurance ID Number: ______________________________ **Group Number:** _________________________

Employer: ____

Business Phone: ____

If you have additional insurance, please complete below:

Dental Insurance Company: ____

Subscriber Name: ____ *D.O.B.* ________________________

Subscriber Social Security Number: ____

Insurance ID Number: ______________________________ *Group Number:* _________________________

Employer: ____

How did you hear about us?

____

Date of last Dental Visit: ____

Previous Dentist: ____

Have you had any trouble associated with previous dental treatment? ______________________________

Emergency contact: ____

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MEDICAL INFORMATION

Physician's Name: ____

Physician's Phone number: ____

Are you in good health? ____

Date of last physical exam: ____

Have you been admitted to a hospital in the last three years? ___________________________________

If yes, for what reason? ____

Are you taking ANY medication? Yes: __________ **No:** __________

If yes, please list: ____

Please circle any medications to which you are allergic:

PENICILLIN	**NOVOCAINE**	**ASPIRIN**	**CARBOCAINE**
CODEINE	**SULFA**	**XYLOCAINE**	**Other:** _________

Please circle ANY that you **may** *have OR* **have** *had:*

AIDS	**Drug Addiction**	**Asthma**	**Stroke**
Alcoholism	**Fainting Spells**	**Skin Problems**	**Liver Disease**
Anemia	**Rheumatic Fever**	**Muscle Problems**	**Allergies**
Epilepsy	**Kidney Trouble**	**Heart Troubles**	**Tumor**
Low Blood Pressure	**HIV Positive**	**Arthritis**	**Hypoglycemia**
High Blood	**Jaundice**	**Heart Murmur**	**Other:**
Pressure	**Sinus Problems**	**Tuberculosis**	______________
Diabetes	**Radiation Therapy**	**Hepatitis**	

CONSENT FOR TREATMENT

I understand that it is the responsibility of this patient's parent/legal guardian to inform Dr. Lester of any **changes in the** patient's health. I, the undersigned and legally responsible party, authorize and request **the performance of dental services on this patient and, further the performance of any operation rendered by the dentist and his staff. I also authorize the administration of such anesthetics or analgesics, local or inhalation which the doctor may deem advisable. Furthermore, I will be responsible for any financial obligations incurred for dental treatment upon the above name patient. I understand that the charges are my personal responsibility regardless of insurance benefits.**

Signature: ____ **Date:** _________________

Parent/Guardian