MEDICAL HISTORY

Patient's name____Male_____Female_____

Birth date________________________

Address____

Mother's phone: Home________________________ Cell_____________________________

Email____

Referred by____

Reason for visit: Tongue tie_____ Lip tie_____ Consult ______

Parents: Mother's name (print)____________________________   Date of birth____________

Father's name(print)______________________________   Date of birth_____________

Please list any allergies/medical conditions_______________________________________

INSURANCE INFORMATION

DENTAL INSURANCE:
Insurance company name_________________________________
Policy holder name_______________________________________Date of Birth_____________
Policy holder's employer (if employer sponsored)____
Group #_________________________ ID/Member # (if none, SS#)_________________________

MEDICAL INSURANCE
Insurance company name__________________________________
Policy holder name_______________________________________Date of Birth_______________
Policy holder's employer (if employer sponsored)____
Group #_________________________ID/Member # (if none, SS#)___________________________

Person responsible for payment (print)____
Signature of parent or guardian____