Dudley Katz, D.D.S.
Beverly Jimenez, D.D.S.

DATE:_____

PATIENTS NAME:_____

ADDRESS:_____ APT #:_____

CITY:_____ZIP CODE:_____P.O. BOX #:___Yes___No

HOME PHONE:_____ BIRTHDAY:_____ Male or Female

RESPONSIBLE PARTY INFORMATION

NAME:_____S.S.#:_____

ADDRESS:_____APT # :_____

CITY:_____ZIP CODE:_____P.O. BOX #: ___Yes ___No

HOME PHONE:_____WORK PHONE:_____

RELATIONSHIP TO PATIENT:_____ BIRTHDATE:_____

SPOUSES NAME:_____ WORK PHONE:_____

SPOUSES BIRTHDATE:_____ S.S.#:_____

INSURANCE INFORMATION

POLICY HOLDER:_____ S.S.#:_____

EMPLOYER:_____ GROUP#:_____

INSURANCE COMPANY:_____

INSURANCE CO. ADDRESS:_____

EMERGENCY CONTACT INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:_____
RELATIONSHIP:_____ PHONE:_____
ADDRESS:_____ ZIP:_____
IS THIS YOUR CHILD'S FIRST DENTAL VISIT ?:_____

MEDICAL INFORMATION

1. Is there any recent change in your child's health? Y N
2. Is your child under a physicians care for anything? Y N
   Physician Name & Phone Number: _____
3. Have there been any recent serious illnesses or hospitalizations? Y N
4. Is your child allergic to any medications, food, etc.? Y N
   If so, Please List: _____
5. Does your child have a history of, or has your Doctor ever discussed a HEART MURMUR ? Y N
6. Does your child have any behavior problems or special needs? Y N
7. Circle if your child is taking any of these medications:
   Antibiotics Aspirin Seizure Meds Insulin
   Other Medications,Please List:_____

8. Circle if your child has a history of:
   Heart Disease Rheumatic Fever Seizure Disorder Diabetes Blood Disorder

   Healing/Bleeding Problems Liver Disorder Hepatitis Tuberculosis Asthma

9. Circle if your child or any family member has ever had:
   Tobacco Habit Aids or HIV Tuberculosis Drug Abuse Alcohol Abuse

10. Circle if your child has any of the following habits:
    Pacifier Baby Nursing Bottle Thumb or Finger Habit

11. Has your child ever had any bad reaction to medical or dental treatments ? Y N
12. Do you have well water? Y N
    If so, does your child take a fluoride supplement? Y N

Updates:_____ _____ _____ _____ _____ _____ _____ _____

CONSENT AND ACKNOWLEDGMENT

I, the patient, or the Parent or Guardian of a minor Patient, hereby acknowledge the following information has been read by me, that I understand the information fully, and that I agree this day to the following:

A. That a $20.00 fee will be charged for any failed appointment, where the Patient or the Parent or Guardian of a minor Patient, has not provided 24 hours advance notice. If there

are 2 failures we will not be able to see the patient in our offices anymore.

B. I am responsible for all fees for services rendered by **Dudley Katz, D.D.S., P.C.,** that were rendered to the Patient and which are not paid by my Dental Insurance. Failure to supply proper forms and information will necessitate payment in full by the Patient, Parent, or Guardian.

C. That I will make prompt payment to **Dudley Katz, D.D.S., P.C.,** for all charges incurred by the Patient; and a $10.00 monthly serivice charge shall be assessed for any charge not paid by me within ninety (90) days of billing, beginning from the date services were rendered.

D. I further agree that if this matter is referred to a collection agency, I will pay the collection costs, not to exceed 40% of the amount I owe. Also, a returned check fee will be charged according to bank service fees assessed.

E. I hereby give my consent as Patient, Parent or Guardian of a minor Patient, if applicable to this Patient, to **Dudley Katz, D.D.S., P.C.,** to treat my child. I am aware that behavior modification procedures may be invoked to facilitate treatment. I also consent to allow the staff to assist Dr. Katz and/or his Associates in the treatment of my child. I acknowledge, attest and agree that no guarantee of success, or degree of success, has been given or implied.

F. That my consent and adherence to these terms and conditions contained herein shall begin this date and extend to all future treatment(s) rendered by **Dudley Katz, D.D.S., P.C.**

_____(Seal) _____

Patient Date

_____(Seal) _____

Parent or **Guardian** of Patient Date

(If Patient is a Minor) Responsible Party