

Allan P. Capinpin, D.D.S.

MINOR/STUDENT AGE MINOR-PATIENT INFORMATION

Today's Date _____

Home Phone() _____

Cell Phone () _____

Text to cell is ok

Name _____

Birth date ____ / ____ / ____ Age ____

Address _____

City State Zip

School name _____

City State

PARENTS INFORMATION

Father's (guardian) Name _____ Resides with? _____

Birthdate ____ / ____ / ____ SS# _____ Employer _____

PHONE: Home _____ Work _____ Cell _____

Mother's (guardian) Name _____ Resides with? _____

Birthdate ____ / ____ / ____ SS# _____ Employer _____

PHONE: Home _____ Work _____ Cell _____

As a courtesy service to our patients, we will bill your insurance company, as long as you have provided all necessary information. Your insurance policy is a contract between you, your employer and the insurance company. Insurance policies vary and services provided may not be covered. We cannot guarantee insurance payment, as the insurance carrier will not guarantee payment before a claim is received. Please contact your employer or insurance carrier if you have questions about your policy coverage.

PRIMARY CARRIER

SECONDARY CARRIER

(The insured parent with the closest birth month to January, is primary, unless, under court order. Please contact your provider)

Insurance Company _____

Insurance Company _____

ID/MEMBER # _____

ID/MEMBER # _____

Group # _____

Group # _____

Relationship to patient: Mom Dad Self

Relationship to patient: Mom Dad Self

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to **Dr. Capinpin** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Capinpin to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

GENERAL INFORMATION

Whom may we thank for referring you? _____ Relationship _____

Contact in case of emergency _____ Phone() _____

CONSENT FOR DENTAL TREATMENT

I hereby give consent to any advisable and necessary dental procedures, medications, anesthetics or necessary radiographs (x-rays), to be administered by Dr. Allan Capinpin or the supervised licensed staff for diagnosis and treatment of my child's dental condition.

Parent/Guardian Signature

Date

(Continued on back)

Patients Name: _____

MINOR/STUDENT AGE MINOR PATIENT-MEDICAL HISTORY

Physician's Name _____ Medical ID# _____ Phone () _____

Has he/she been under the care of a medical doctor during the past two years? Yes No

If yes, for what _____

Has he/she been a patient in the hospital during the past five years? Yes No

If yes, for what _____

Due to constant changes in the medical and dental health fields it is very important of Dr. Capinpin to know about your child's over all health. Please circle "yes" or "no" if he/she have or have had any of the following:

- | | | |
|--------------------------------------|-----------------------------------|----------------------------|
| yes no Anemia | yes no Diabetes | yes no Kidney Trouble |
| yes no Angina Pectoris | yes no Diet (special, restricted) | yes no Liver Disease |
| yes no Arthritis/Rheumatism | yes no Eating Disorders | yes no Nervous/Anxious |
| yes no Artificial Heart Valve | yes no Emphysema | yes no Pacemaker |
| yes no Artificial Joints (hip, knee) | yes no Epilepsy/Seizures | yes no Psychiatric Care |
| yes no Asthma | yes no Fainting/Dizzy Spells | yes no Radiation Therapy |
| yes no BRONJ | yes no Glaucoma | yes no S.T.D. |
| yes no Back Problems | yes no HIV/AIDS | yes no Sickle Cell Disease |
| yes no Blood Transfusion | yes no Hay Fever | yes no Sinus Trouble |
| yes no Bruise Easily | yes no Headaches (Frequent) | yes no Stroke |
| yes no Cancer/ Chemotherapy | yes no Heart Attack | yes no Thyroid (high, low) |
| yes no Chronic Cough | yes no Heart Surgery | yes no Tuberculosis |
| yes no Cold Sores/Fever Blisters | yes no Hemophilia | yes no Ulcers |
| yes no Congenital Heart Defect | yes no Hepatitis (A,B,C) | yes no Yellow Jaundice |
| yes no Contact Lens | yes no High Blood Pressure | |
| yes no Cortisone Treatments | yes no High Cholesterol | |

Any Other Condition not listed? _____

MEDICATIONS

List medications you are currently taking and its uses _____

List herbal remedies or vitamins you take _____

ALLERGIES

Are you aware of having an allergic (or adverse reaction) to any medications or substance? _____

If yes, please list _____

WOMEN

Are you: Pregnant?Yes (months _____) Nursing? Yes No

Taking Birth control Pills? Yes No

I understand the above information is necessary to provide the minor child or myself with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

I understand that it is my responsibility to inform the doctor if there is ever a change in health or medication.

Parent/Guardian Signature

Date

Dr. Capinpin has reviewed the above Health History with the patient/guardian.

Signature

Date