Miranda Lacy D.D.S., P.A.

3604 Preston Rd Ste 400
Plano, TX 75093

Tell Us About Your Child

Today's Date:_____

Child's Name:_____

Nickname: _____ □ Male □ Female

Child's DOB:___/___/_____ Age: ____

Home Address:_____

_____
CITY STATE ZIP

Best Way To Be Contacted:

Cell #:(___)_____Hm #:(___)_____

SS #:_____ DL #:_____

School: _____

Who Is Accompanying The Child Today?

Name:_____ Relation:_____

Do you have legal custody of this child?

□ Yes □ No

In the event of an emergency, who should we contact?

Name:_____

Relationship:_____

Cell/Home: (____)_____

Work: (____)_____

Dental Insurance

Insurance Co. Name, Address and Phone #:

_____

_____

Group, Plan, Local or Policy #:_____

Insured's Name:_____

Relationship to Patient:_____

Insured's DOB:___/___/____

Insured's ID#:_____

Insured's Employer and Address:

_____

How did you hear about our office?

_____

Other family members seen by us:

_____

Who is responsible for making appointments?

_____

Person Responsible For Account

Name:_____

Relation:_____

Billing Address: _____

_____

Parent Information

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Mother ☐ Step-Mother ☐ Guardian

Name:_____ DOB:_____

Cell #:(___)_____Wk #:(___)_____

Employer:_____

Email:_____

SS #:_____

☐ Father ☐ Step-Father ☐ Guardian

Name:_____ DOB:_____

Cell #:(___)_____Wk #:(___)_____

Employer:_____

Email:_____

SS #:_____

Please list all prescription, over-the-counter medications or supplements your child takes:

_____

_____

_____

_____

_____

Drug Allergies

____ Aspirin
____ Erythromycin
____ Codeine
____ Jewelry or Metals
____ Dental Anesthetic
____ Acrylic
____ Latex
____ Penicillin
____ Sulfa Drugs
____ Tetracycline

Other:_____

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Medical History

CHECK ALL THAT APPLY

_____ AIDS/HIV Positive
_____ Abnormal Bleeding / Hemophilia
_____ Anemia
_____ Asthma or Hay Fever
_____ Auto-Immune Disease
_____ Blood Transfusion
_____ Cancer: Type/Dates_____
_____ Chronic Cough
_____ Cold sores/Fever blisters/Mouth ulcers
_____ Congenital heart defect
_____ Crohns Disease
_____ Diabetes: Date Diagnosed: _____
Type_____
_____ Difficulty Breathing
_____ Eating Disorders
_____ Epilepsy / Seizures / Fainting Spells
_____ Excessive Thirst
_____ Heart Murmur
_____ Hospitalized for Any Reason
Specify:_____
_____ Hypoglycemia
_____ Immune Suppressed
_____ Irregular Heartbeat
_____ Mitral Valve Prolapse
_____ Psychological Problems
_____ Rheumatic fever / Scarlet fever
_____ Severe / Frequent Headaches
_____ Sickle Cell Disease / Traits
_____ Seasonal Allergies
_____ Sinus Problems
_____ Stomach Ulcers / Colitis
_____ Surgery in the last 12 months
_____ Tuberculosis (TB)

Currently under the care of a physician?

Please Explain:_____

Pharmacy:_____ (__)_____

Please list any other serious medical condition(s) that your child has ever had:

_____
_____
_____
_____

The information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services I may need during diagnosis and treatment with my informed consent.

_____

Signature (Parent/Guardian) Date