GLENWOOD Meadows DENTAL

BENJAMIN COON, DDS

PERSONALIZED, COMFORTABLE CARE

Tell us about your child:

Today's Date: ____/_____/_____ Childs Name: _____

Preferred Name: _____ Male_____ Female ____

Child's Birth date: _____/_____/_____

Who may we thank for referring you? _____

Please indicate if you have any dental concerns regarding your child:

_____

Mother's Information _____ Step Mother ____ Guardian

Name: _____ Birth Date: ____/____/_____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Phone: _____ SSN: _____-____-_____

Father's Information ___ Step Father __ Guardian

Name: _____ Birth Date: ____/____/_____

Mailing Address: _____ City: _____ State:_____ Zip:_____

Phone: _____ SSN: _____-____-_____

Please indicate if there is any **medical condition** your child may have, that the doctor should know about: _____

_____

Please indicate if your child is taking any **medication** that the doctor should know about:

_____

_____

X _____

Patient, Parent or Guardian Signature Date:

X _____

Dentist Signature Date:

***I certify that I have read and understand the above information to the best of my knowledge; the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health**.