

TriMark Dental Clinic, LLP



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www.TriMarkDental.com

		" " " I I IIIIIAI KD	entarcom			
Date// Child's Full Name:			Nickname:		Age	
		Nic				
Home Address:			City:	_ State	Zip	
E-IVIAII Address :		Cell #	Best C	Contact#		
Father's Name:	Fathe	r's Birthdate	Father's SS#	Fath	erCell#	
rather's Address (if o	different)		City/State/Zin			
rather's Employer		Address				
ramer's Denial Ins. C	ar ins. Co.		Address		Group#	
wiother's Name	Mother	's Birthdate	Mother's SS#	Moth	herCell#	
Mother's Address (if	different)		City/State/Zin			
wither's Employer _		Address				
Mother's Dental Ins.	Co	Address		G	roup#	
Medical History						
Physician's Name	- North Anna	Clinic		Che		
Does your child have	a health problem?			City_		
is there any nearth con	y drugs? YesNo If so dition we should know about? _ een hospitalized? If so, give dateDrug AbuseEpilepsy/Seizures	Yes No 1	f so, What?	Smo	oker	
Arthritis	Fainting	Leukemia		Stro		
Asthma	Heart Disease	Lupus		_	roid Problem	
Bleeding problems	Heart Murmur	Malignancy		I ub	erculosis	
Cancer	Hepatitis ABC	- •	Prolapse w/regurgitatio	.n		
Celiac's	High/Low Blood Pressure	MRSA	which wite guigitatio			
Diabetes	HIV Positive		nerapy/Chemo		you Pregnant?	
			стару/спето	Othe	er	
Dental History						
*	u brought your child for dantal a	0=0				
this your child's first	u brought your child for dental co	Dota - Ch				
Vhat are your concerns	visit to a dentist? Yes No	Date of last v	sit		-	
Vho referred you to thi	s about your child's teeth?	nl				
ignature	s office? We'd like to thank then		D :		_	
-			Date			