TriMark Dental Clinic, LLP

Patricia Lyons DDS Tonya Wason DDS Eric Popp DDS

2130 Kennedy Road Janesville, WI 53545 608-752-7452

www.TriMarkDental.com

Date ____/____/____ Birthdate _____ Age____

Child's Full Name:_____ Nickname:_____ SS# _____-____-_____

Home Address:_____ City:_____ State_____ Zip_____

E-Mail Address :_____ Cell #_____ Best Contact#_____

Father's Name:_____ Father's Birthdate_____ Father's SS# _____ FatherCell#_____

Father's Address (if different) _____ City/State/Zip_____

Father's Employer_____ Address_____

Father's Dental Ins. Co. _____ Address _____ Group#_____

Mother's Name _____ Mother's Birthdate_____ Mother's SS# _____ MotherCell#_____

Mother's Address (if different) _____ City/State/Zip_____

Mother's Employer _____ Address _____

Mother's Dental Ins. Co. _____ Address _____ Group#_____

Medical History

Physician's Name _____ Clinic _____ City _____

Does your child have a health problem? _____

Does he/she take medication for anything? ___ Yes ___No If so for what? _____

Is he/she allergic to any drugs? ____ Yes ___No If so , what? _____

Is there any health condition we should know about? ___ Yes ___ No If so, What? _____

Has your child ever been hospitalized? If so, give date and reason. _____

Allergies	Drug Abuse	Kidney Disease	Smoker
Anemia	Epilepsy/Seizures	Liver Disease	Stroke
Arthritis	Fainting	Leukemia	Thyroid Problem
Asthma	Heart Disease	Lupus	Tuberculosis
Bleeding problems	Heart Murmur	Malignancy	
Cancer	Hepatitis ABC	Mitral Valve Prolapse w/regurgitation	
Celiac's	High/Low Blood Pressure	MRSA	Are you Pregnant?
Diabetes	HIV Positive	Radiation Therapy/Chemo	Other _____

Dental History

Explain briefly why you brought your child for dental care. _____

Is this your child's first visit to a dentist? Yes___ No____ Date of last visit _____

What are your concerns about your child's teeth?_____

Who referred you to this office? We'd like to thank them! _____

Signature_____ Date_____