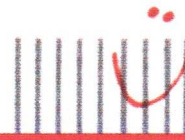




# TriMark Dental Clinic, LLP



**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 \_\_\_\_\_