WELCOME TO RHODES DENTAL e would like to welcome you and your child to our office. Our preventive wisit pleasant and education (330) 264-5522 Visit pleasant and educational. Our practice is based on preventive care. We strive to Visit pleasant and educational. Our practice is based a beautiful smile that lasts a lifetime.

Vestrive

*Vestr control mandated by OSHA, the CDC and the ADA. ABOUT 0 **ABOUT YOUR CHILD** YOU Name: Nickname: SS #: Birthdate: Relationship to child: Your home phone and address, if different from child's: Special interests, sports or hobbies: Address Apt/Condo # City Home address: Occupation: ___ Employer: __ Home phone: (Referred by: Pager/Car phone: [__ DENTAL INSURANCE COMPANY #1 DENTAL INSURANCE COMPANY #2 Dental Ins. Co.: Dental Ins. Co.: Insurance Co. Phone #: (____)___ Insurance Co. Phone #: (____) Group / Policy #: ____ Group / Policy #: ____ This Dental Insurance is provided through: This Dental Insurance is provided through: Policy owner's name: ___ Policy owner's name: ___ Relationship to child: Relationship to child: Policy owner's SS #: __ Policy owner's SS #: Policy owner's birthdate: __ Policy owner's birthdate: ___ Policy owner's employer: Policy owner's employer: CONTINUED ON BACK

medica medica	ne following all conditions of problems? Problems of problems.
Are there any dental problems that you are aware of at present? Yes No If yes, please explain: Has your child any of the medical solution of t	ne following all conditions of problems? Problems of problems.
present? Yes No If yes, please explain: any of the medical or Does your child brush his / her teeth daily? Yes No Please rate your child's oral health: Good Fair Poor Is your child currently under the care of a physician? Yes No Child's physician: Yes No His / Her phone #: Yes No If yes, please list: Yes No In the event of any emergency, whom should we contact? Name: Relationship: Phone #2: If yes, please list: If yes, please list: If yes, please list: If yes, please list: Yes, please list: If yes, plea	ne following all conditions of problems? Problems of problems.
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Does your child brush his / her teeth daily?	pital Stays erations Problems of ons / Epilepsy mpairment rmur blems of
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Is your child currently under the care of a physician? Yes No Child's physician: Y N Cancer His / Her phone #: Y N Convulsion The approximate date of last visit: Y N Diabetes Please rate your child's medical health: Good Feir Poor Is your child allergic to any drugs? Yes No If yes, please list: Y N Heart Mur Y N Herophilit Y N Herophilit Y N Hyperactiv Y N Hemophilit Y N Hyperactiv Y N Hyperactiv Y N Hemophilit Y N Hyperactiv Y N Hypera	Problems of ons / Epilepsy mpairment rmur blems of
Child's physician: His / Her phone #: The approximate date of last visit: Please rate your child's medical health: Good Fair Poor Is your child allergic to any drugs? Yes No If yes, please list: Does your child need to be premedicated before dental treatment? Yes No In the event of any emergency, whom should we contact? Name: Relationship: Phone #2: Y N Cancer Y N Convulsion Y N Heart Mur Y N Heart Mur Y N Heart Mur Y N Heart Prot Any Kind Y N Hemophilit Y N HIV+ / All Y N Hyperactiv Y N Rheumatic Fever Are there any other medical condition If yes, please list: Phone #2:	ons / Epilepsy mpairment rmur blems of
His / Her phone #: The approximate date of last visit: Please rate your child's medical health: Good Fair Poor Is your child allergic to any drugs? Yes No If yes, please list: Yes No If yes, please list: Yes No If yes, please list: Yes No In the event of any emergency, whom should we contact? Name: Relationship: Phone #2: Phone: Phone #2: If yes, please list: If yes, please list	mpairment rmur blems of
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Does your child need to be premedicated before dental treatment?	
In the event of any emergency, whom should we contact? Name: Relationship: Phone: Phone #2: If yes, please list:	
In the event of any emergency, whom should we contact? Name: Relationship: Phone: Phone #2; If yes, please list:	: / Scarlet
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that it will be held in the strictest of confidence, and it is my responsibility to infor	rm this
office of any changes in my child's medical status. I authorize the dental staff	to L
perform the necessary dental services my child may need.	9
	70
The Parent or Guardian who accompanies the child is responsible for paymen	nt o
at time of service unless prior arrangements have been approved.	of I
Signature of parent or guardian: Date:	1 2 0
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1/0 30.4 67	100
hank you for filling out this form completely. It will enable us to give your child the best dental con	Log
If you or your child have any questions please feel hee to ask us at any time	1009
have any ques of the to ask us	ne postible
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