Welcome to ADC, Kids!

Christopher Lefebvre, DDS
Timothy Greer, DDS

Personal Information:

Name: _____ DOB: _____ SSN#: _____

Gender: M F Hobbies: _____ Fav. Color: _____

Address: _____ City, State, Zip: _____

Preferred First Name: _____ In case of emergency, contact: _____ #_____

Who invited you to our Practice? _____

Responsible Party Information:

Name: _____ Relation: _____

DOB: _____ SSN#: _____ DLN#: _____

Is this person currently a patient in our Practice? Yes No

How May We Contact Responsible Party?

Home #: _____ Work #: _____Ext._____ Cell #: _____

Where do you prefer to receive calls? (Circle one above) When? Time: _____ Day: _____

Fax #: _____ Email address: _____

Responsible Party Employment Information:

Employer: _____ Occupation: _____

Address: _____

City, State, Zip _____

Responsbile Party Insurance Information:

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured SSN#: _____ Insured DOB: _____ Policy #: _____

Insurance Company: _____ Address: _____

Secondary Insurance?: Yes No

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured SSN#: _____ Insured DOB: _____ Policy #: _____

Insurance Company: _____ Address: _____

Insurance Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when by current treatment plan is completed or one year from the date signed below.

_____ _____ Date _____

Signature of Patient, Parent, Guardian or Representative Printed Name

Medical Information:

Minor/Child's Physician _____ City/State _____ Phone _____

Date of Last Physical Exam _____ Results _____

	YES	NO
Is Minor now under the care of a Physician?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been Hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check box.

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

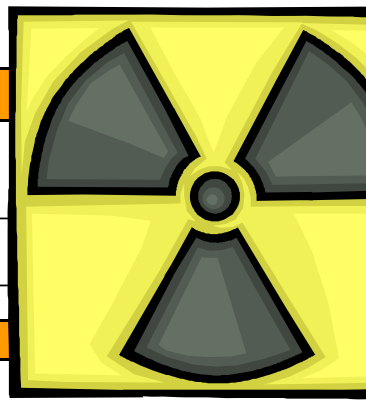
The above named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining payable insurance benefits or the benefits for related services. This consent will end when the current treatment plan is completed or one year from the date the current treatment plan is signed.

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Parent, Guardian, or Personal Representative Date



Emergency Contact Information:

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Photographic Release Authorization:

The Doctors and our Team often take digital photos to document the condition of a patient's teeth and gums, both before and after any treatment that we render. This serves to educate both you and other patients on certain dental conditions, as well as possible results of the treatment options that we offer our clients. We may ask you for a written testimonial of your satisfaction of such procedures to discuss with other patients considering similar treatments. By signing below, I am giving Avon Dental Centre, Inc., permission to use these photos in an anonymous fashion for such educational and testimonial purposes.

Parent/Guardian Signature _____ Date _____