TriMark Dental Clinic, LLP

Mark Karrels DDS **Patricia Lyons DDS** **Tonya Wason DDS** **Eric Popp DDS**

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www.TriMarkDental.com

Date ____/____/____ Birthdate _____ Age____

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

Home Address:_____ City:_____ State_____ Zip_____

E-Mail Address :_____Cell #_____ Home Telephone#_____

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

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# _____

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. _____

Hepatitis	Heart Murmur	Kidney Disease	Liver Disease
Artificial Joint	Thyroid Problems	Lupus	Smoker
MRSA	Diabetes	Fainting	Asthma
Mitral Valve Prolapse w/ regurgitation	Rheumatic Fever	Malignancy	Epilepsy/Seizures
HIV Positive	High/Low Blood Pressure	TB	Arthritis
Bleeding Problems	Heart Disease	Radiation Therapy/Chemo	Glaucoma
Heart Attack/Stroke	Females: Are you Pregnant?	Anemia	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_____