Drs. Phil and Greg Wolkstein
Dentistry for Children and Young Adults
841Blossom Hill Road, #210
San Jose, CA 95123
(408) 578-6550

1. Father's Name _____SS#_____
2. Mother's Name_____SS#_____
3. Marital Status: Married _____Divorced _____Single_____
4. Home Address _____ 5. Home Phone _____
   Street Cell Phone _____
   _____ Email_____
   City State Zip
6. Father's Employer _____Father's Full Birthday _____
   Bus. Address _____Dental Insurance Co. _____
   Bus. Phone _____Group# _____Union Local# _____
7. Mother's Employer _____Mother's Full Birthday _____
   Bus. Address _____Dental Insurance Co. _____
   Bus. Phone _____Group # _____Union Local# _____
8. Child Lives With: Father ___ Mother ___ Stepfather ___ Stepmother ___ Other ___
9. Is your child adopted? Yes ___ No ___
10. In case of emergency and parent unavailable, call: _____Phone_____
11. Whom may we thank for referring you to our office?_____

CHILD'S HISTORY

Child's Name _____Nickname_____

Age _____ Birthday ____/____/____ Sex: Boy ___ Girl ____ Child's Physician: Dr. _____

Names of any other of your children already being treated here: _____

	Yes	No
1. Has your child ever had heart trouble, heart murmur, bleeding disorder, epilepsy, brain injury, diabetes, Asthma, kidney or liver disease: (If yes, circle which ones)	___	___
2. Does your child have any other medical, emotional, mental, or learning disabilities? (Explain) _____	___	___
3. Has your child or any one in your family ever been told that they either have or are a carrier for the aids virus?	___	___
4. Does your child have any speech or hearing defects? (if yes, circle)	___	___
5. Does your child have any allergies? List: _____	___	___
6. Does your child have any physical handicaps or disabilities? Explain _____	___	___
7. Has your child ever been hospitalized? Explain _____	___	___
8. Is your child taking any medications now? List _____	___	___
9. Does your child take any type of fluoride with vitamins or separately? (Circle)	___	___
10. Does your child have a finger, thumb, pacifier, or other sucking habit now? (if yes, circle)	___	___
11. Is there any history of mouth injuries? When and how? _____	___	___
12. Has your child ever experienced any unfavorable reaction from any previous dental or medical visits? Explain _____	___	___

13. Child's previous dentist: Dr. _____ Date of last dental visit _____
14. Please describe anything that you would like to bring to our attention about your child, be it physical, or Psychological, that might help us to treat him or her better.

PERMIT FOR DENTAL SERVICES UPON A MINOR

1. I, being the parent (or guardian) of _____ do hereby authorize and request the performance of dental services upon the person of this patient, and authorize whatever procedures that the judgment of Dr. Wolkstein may dictate during the treatment after initial discussion with me. This may include the administration of local anesthetics, sedatives, or medications as deemed necessary by Dr. Wolkstein for the comfort and well being of the child. (You may request a written description of our procedures.)
2. Your child's first visit will include an oral examination, x-ray diagnosis (when deemed necessary), and a cleaning and fluoride treatment. You will then be informed of all services and given a cost estimate before any further treatment is rendered for your child.
3. I acknowledge full responsibility for the payment of services rendered by Dr. Wolkstein.

Date: _____ Signed _____ Relationship to patient_____