Welcome to the Office of
Dr. Russell and Dr. Burton

Please Print:
Today's Date: ____________________
Child's Name: ____________________ Sex: ______________
Birthdate: ________________________ Age: ______________
SS#: ___________________________
Child's Home Address: ____________________________________
City/State/Zip:____

Responsible Party Information:
Mother's Name: _____________________ SS#: _____________
Address: ____
City/State/Zip: ____
Birthday: _________________ Employer: __________________
Home Phone #: __________ Wk #: _________ Cell #: ____________

Father's Name: _____________________ SS#: _____________
Address: ____
City/State/Zip: ____
Birthday: _________________ Employer: __________________
Home Phone #: __________ Wk #: _________ Cell #: ____________

Primary Dental Insurance: _________________________________
Subscriber's Name: __________________ Birthday: ______________
SS #: _________________ Employer: ________________________
Group #: _______________ Ins Co Ph #: ______________________

Secondary Dental Insurance: _______________________________
Subscriber's Name: __________________ Birthday: ______________
SS #: _________________ Employer: ________________________
Group #: _______________ Ins Co Ph #: ______________________

I, the undersigned, certify that I (or my dependent) have insurance coverage with _______________ and assign to Dr. Russell/Dr. Burton 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____________________ Date: __________
Relationship to Patient: ______________________

Acknowledgment of receipt of Notice of Privacy Practices:
I have received of a copy of this office's Notice of Privacy Practices.
Signature: ________________________ Date: ____________

Please list all parties/persons we can share your treatment or personal information with:____
____

Dental History:
Is this your child's first visit to the dentist? Y or N
Has your child had a bad dental experience? Please explain if yes.
____
Reason for today's visit: _____________ Former Dentist: _________
Date of last Dental visit: ______________ Last x-rays: _____________

Please list any and all medications your child takes:____
____

Please circle yes or no to the following questions:
Has your child ever had any of the following?

Asthma	Y or N	Rheumatic Fever	Y or N
Cancer	Y or N	Cong. Heart Defect	Y or N
Hepatitis	Y or N	Handicaps/disabilities	Y or N
HIV/AIDS	Y or N	Convulsions/Epilepsy	Y or N
Hemophilia	Y or N	Tuberculosis	Y or N
Diabetes	Y or N	Abnormal Bleeding	Y or N
Heart Murmur	Y or N	Developmental Delays	Y or N

Other: ____________________

Allergies:

Aspirin	Y or N	Local Anesthetic	Y or N	Barbiturates	Y or N
Codeine	Y or N	Penicillin	Y or N	Sulfa	Y or N
Iodine	Y or N	Latex	Y or N	Other: _________	

All of the information above is true and accurate to the best of my knowledge.
Completed By: _______________________ Date: ___________
Relationship to Patient: ____

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