Dr. Rebecca Lee, D.D.S.
11200 Corbin Avenue, Suite 108
Northridge, CA 91326
(818) 831-8252

WELCOME! How did you choose our office? ____

PATIENT AND FAMILY RECORD

Name of Child: ________________________
Age: ____ Date of Birth: _______________
School: ______________________________
Nickname: ___________________________

Siblings: _______________ Age: ___
_______________ Age: ___
_______________ Age: ___
_______________ Age: ___

Home Address _________________________
City ______________________ZIP_________Phone _________________

If applicable, the parent and legal guardian are not the same, please fill out the information below for the legal guardian and indicate the legal guardian's relation to the child.

Father's Full Name	____________________	Mother's Full Name	_________________________
Address (if different)	____________________	Address (if different)	_________________________
	____________________		_________________________
Home Phone	____________________	Home Phone	_________________________
Social Security #	____________________	Social Security #	_________________________
Occupation	____________________	Occupation	_________________________
Birth Date	________________	Birth Date	______________
Employer	____________________	Employer	_________________________
Business Address:	____________________	Business Address	_________________________
Business Phone	____________________	Business Phone	_________________________
Cell Phone	____________________	Cell Phone	_________________________

If family is NOT living together, person financially responsible for account: ________________________
Please note that if the child's legal guardian is unable to accommodate the child to his/her appointment, written authorization from the legal guardian will be required for another adult (nanny, sibling, grandmother, etc.) accommodate your child and aid in any necessary decisions regarding your child's treatment.

DENTAL HISTORY

1. Is this your child's first dental visit? YES NO
   Previous dentist _________________________City ______________________
   Date of last visit __________________
2. Has your child had an unfavorable experience in a previous dental or medical office? YES NO
3. Have there been any traumatic injuries to your child's teeth or jaws (falls, blows, chips, etc.)? YES NO
4. Does your child receive fluoride vitamins, tablets, water, etc.? YES NO

5. Name of Parent's dentist ___________________________________City ___________________

DENTAL INSURANCE INFORMATION

First Policy
Name of Insured _______________________Relationship to Child __________ Employee ID# _________

Insurance Company ________________________Employer________________Group/Policy # __________

Second Policy
Name of Insured _______________________Relationship to Child __________ Employee ID# _________

Insurance Company ________________________Employer________________Group/Policy # __________

I hereby authorize Dr. Rebecca Lee Pair and staff to perform cleaning and fluoride treatment, as well as diagnostic procedures, including x-rays, photographs, and models, if necessary, in order to properly diagnose and record any and all dental conditions.
I understand that I am financially responsible for all charges for services rendered. I realize payment is expected for service rendered at the time of the first visit. Financial arrangements for subsequent treatment may be made following diagnosis.
This consent is in effect until cancelled by writing.

Signature _______________________________ Relationship to child ______________ Date __________