David A. Tecosky D.M.D. 2438 Brown Street Philadelphia, PA 19130 (215)236-6200

Child Registration Today's Date_____

Child's Name _____ Parent/Guardian _____
(First, Middle, Last)

Sex: Male/Female Date of Birth ____/____/_____ S.S. # _____-____-_____
(MM) (DD) (YYYY)

Address _____

_____

Guardian Information

_____ _____
Name Relationship

Home_____ Work _____

Cell _____ E-mail _____

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Do you have dental insurance? ____ Name of Insurance _____

Subscriber information

Name_____ Relationship _____

Date of Birth_____ SS# _____

Address (if different from patient) _____

_____

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Primary Physician _____
(Name, address, phone#)

Medical History: Please indicate if the child has been treated for any of the following conditions

Y/N Asthma Y/N Seizures/Epilepsy Y/N Bleeding/ Clotting Disorders
Y/N Diabetes Y/N Hypertension Y/N Heart Condition
Y/N Allergies IF Y Please specify_____
Any conditions not listed? _____

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Who may we thank for referring you to our office? _____

Please list any special concerns and what you would like to have done today.

_____

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