



Normandy Dental
 713- 451-8845
 6830 E Sam Houston Pkwy N #100
 Houston, TX 77049
 www.normandydental.com

Christine Manning, D.D.S.
 Bryant Fraker, D.D.S.
 Peter Manning, D.D.S.
 Raul Saenz, D.D.S.
 Raymond Dao, D.D.S.
 Rahul Gandhi, D.M.D.

We are happy to have you here at Normandy Dental and want your appointment to go as smoothly as possible. Parents are asked to remain in the reception area since the doctor needs the child's undivided attention. However, please feel free to ask questions concerning treatment, appointments or fees.

Patient _____ DOB _____ Sex (circle one) M F
 Address _____ City _____ State _____
 Zip _____ Home phone _____ Cell phone _____
 E-mail _____

Father's Name _____ DOB _____
 Employer _____ Wk phone _____
 Cell phone _____ SS# _____
 Insurance Co. _____ Policy/ID# _____

Mother's Name _____ DOB _____
 Employer _____ Wk phone _____
 Cell phone _____ SS# _____
 Insurance Co. _____ Policy/ID# _____

Account will be paid today by cash ___ credit card ___ check ___ Dr. will quote fees and payment is required at that time. No temporary checks accepted. You must have a current TDL and work phone number available.

How did you hear about our office? _____

Purpose of visit _____

(Child's Form)

HEALTH HISTORY

Has your child ever been treated for or diagnosed for any of the following? Indicate by answering yes or no.

YES or NO	Heart Trouble	YES or NO	Heart Murmur
YES or NO	Rheumatic Fever	YES or NO	Valve Replacement
YES or NO	Asthma	YES or NO	Mitral Valve Prolapse
YES or NO	Kidney Problems	YES or NO	Arterial Grafts
YES or NO	High Blood Pressure	YES or NO	Organ Transplants
YES or NO	Epilepsy	YES or NO	Diabetes
YES or NO	Hepatitis	YES or NO	Joint Replacement
YES or NO	Implants	YES or NO	Tuberculosis
YES or NO	HIV Positive	YES or NO	Shunts (head/body)
YES or NO	AIDS	YES or NO	Other (list below)

Other _____

Please specify any recommendations of precautions you physician may have given you regarding your child's dental work _____

Has your child experienced any ill effects or allergic reaction from Novocain, Penicillin, or any other drug? _____

If yes, please list. _____

List any medications your child is taking (prescribed or not)

Has your child experienced any unfavorable reactions from previous dental work?

Name of medical doctor _____ Phone _____

Signature _____ Date _____

I HEREBY ASSIGN ALL DENTAL AND MEDICAL BENEFITS TO WHICH I AM ENTITLED TO NORMANDY DENTAL . A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID AS AN ORIGINAL. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signature _____ Date _____

