Date:

Gerald R. Berg D.M.D.

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Patient Information… Short Form For Children

Last Name: ______ First Name: ______ M.I. ______

Social Security Number: ______ Date of Birth: ______

Sex: ☐ *M* ☐ *F* Age ______ School Year ______

Address: ______ City: ______ State: ______ Zip: ______

Cell Phone: ______ Home Phone: ______

Person to contact in case of emergency: ______ Phone Number: ______

Responsible Person for this account: ______ Relationship to Patient: ______

Address, Phone numbers, Birthdate, Employer, Email, **(if different than parent or guardian:)** ______

______

Reason for today's visit: ______ Date of last dental visit? ______

______

Medical And Dental Problems

Do you have Medical or Dental problems…?

______

______

______

Allergies…

Do you have any Allergies…?

______

I agree to pay all co-payments and deductibles at the time the service is rendered. When your dental plans maximum yearly amount is reached you will be responsible for the treatments that exceed that limit.

Signature of parent or guardian: ______ Date: ______