

# Thank you for selecting us

Patient Account # \_\_\_\_\_

Today's Date \_\_\_\_\_

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

## Your Child

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Nickname \_\_\_\_\_ SS# \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

SS# \_\_\_\_\_ Drivers License# \_\_\_\_\_

Who is responsible for making appointments? \_\_\_\_\_

Parent or Guardian Information \_\_\_\_\_ Mother \_\_\_\_\_ Stepmother \_\_\_\_\_ Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

SS # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Marital Status \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Parent or Guardian Information \_\_\_\_\_ Father \_\_\_\_\_ Stepfather \_\_\_\_\_ Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

SS # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Marital Status \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

## Primary Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# Dental/Medical Health History (Confidential)

Your Child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient Account # \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated?  Yes  No

Does your child take fluoride supplements?  Yes  No

### Does your child:

Suck Thumb/Finger  Yes  No

Suck/Bite Lip  Yes  No

Bite/Chew Nails  Yes  No

Chew Hard Objects (pencils, etc.)  Yes  No

Grind Teeth  Yes  No

Clench Jaws  Yes  No

Date of Last Dental Visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_

Address \_\_\_\_\_

Has your child had difficulty with previous dental visits?  Yes  No

Has your child ever taken Fen-Phen/Redux?  Yes  No

### Has your child ever had any of the following:

Asthma  Yes  No

Handicaps/Disabilities  Yes  No

Cancer  Yes  No

Tuberculosis  Yes  No

Hepatitis  Yes  No

Diabetes  Yes  No

HIV/AIDS  Yes  No

Rheumatic Fever  Yes  No

Hemophilia  Yes  No

Congenital Heart Defect  Yes  No

Abnormal Bleeding  Yes  No

Heart Murmur  Yes  No

Stomach, Liver or Kidney Problems  Yes  No

Convulsions/Epilepsy  Yes  No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)  Yes  No

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses \_\_\_\_\_ When? \_\_\_\_\_

Is your child currently taking any medications  Yes  No (If yes, please list) \_\_\_\_\_

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)?  Yes  No (if yes, please describe) \_\_\_\_\_

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? \_\_\_\_\_

Please explain any medical problems that your child has: \_\_\_\_\_

### Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Check  VISA  MasterCard  Discover  I wish to discuss the office payment policy

### AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor) \_\_\_\_\_

Date \_\_\_\_\_

Dentist's Review \_\_\_\_\_

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Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_