Today's Date________________

Welcome

to our practice! 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 ______________________________

Nickname ____________________ Sex ________

Birthdate ____________________ Age ________

School ____________________ Grade ________

Child's Home Address ______________________________

City ____________ State ________ Zip ________

Phone ______________________________

Responsible Party

Name ______________________________

Relationship ______________________________

Address ______________________________

City ____________ State ________ Zip ________

E-Mail ______________________________

SS # ______________________________

Who can we thank for referring you? ______________________________

Who is responsible for making appointments?

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________________ Ext. ________

Best time to call ______________________________

Time ____________ Days ____________

____

Mother ☐ Stepmother ☐ Guardian

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________________ Ext. ________

E-Mail ______________________________

Employer ______________________________

Occupation ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name ______________________________

Home Phone ____________ Cell Phone ____________

Work Phone ____________________ Ext. ________

E-Mail ______________________________

Employer ______________________________

Occupation ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ____________ SS # ____________

Insurance Company ______________________________

Group # ____________ Employee # ____________

Additional Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ____________ SS # ____________

Insurance Company ______________________________

Group # ____________ Employee # ____________

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ Financial Options

Dental & 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.

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 Chew hard objects (pencils, etc.) .... ☐ Yes ☐ No
Suck/Bite lip .... ☐Yes ☐No Grind teeth .... ☐ Yes ☐ No
Bite/Chew nails .... ☐Yes ☐No Clench jaws .... ☐ Yes ☐ No
Previous dentist ________ Address ________
Date of last dental visit? ________
Has your child had difficulty with previous dental visits? ☐Yes ☐No
Child's physician ________ Address ________
Phone # ________

Previous Hospitalizations/Surgeries/Serious Illness? When?

________ ________
________ ________
________ ________

Is your child currently taking 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 substance (latex, environmental, etc.)?

____

Has your child ever had any of the following:
Asthma .... ☐ Yes ☐No Stomach, liver or kidney problems .... ☐ Yes ☐ No
Cancer .... ☐ Yes ☐No Handicaps/Disabilities .... ☐ Yes ☐ No
Hepatitis .... ☐ Yes ☐No Tuberculosis .... ☐ Yes ☐ No
HIV/AIDS .... ☐ Yes ☐No Diabetes .... ☐ Yes ☐ No
Hemophilia .... ☐ Yes ☐No Rheumatic Fever .... ☐ Yes ☐ No
A persistent cough or throat clearing Congenital Heart Defect .... ☐ Yes ☐ No
not associated with a known illness Heart Murmur .... ☐ Yes ☐ No
(lasting more than 3 weeks)? .... ☐ Yes ☐No Convulsions/Epilepsy .... ☐ Yes ☐ No
Abnormal Bleeding .... ☐ Yes ☐No

Please explain any medical problems that your child has: ________

____

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.

I have received a copy of this office's Notice of Privacy Practices.

________ ________
Signature of patient or parent if minor Date
Dentist Review:

________ ________
Signature of Dentist Date

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