

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. Thank you.

YOUR CHILD

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS# _____
School _____ Grade _____
Child's Home Address _____
City, State, Zip _____
Phone _____

RESPONSIBLE PARTY

Name _____
Relationship to Patient _____
Address _____
City, State, Zip _____
SS# _____
DL# _____ Birthdate _____
Whom May We Thank for Referring You? _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name _____
Home Phone _____
Work Phone _____ Ext. _____

Best Time to Call _____
Time _____ Days _____

MOTHER Stepmother Guardian

Name _____
Home Phone _____
Work Phone _____ Ext. _____
Employer _____
Occupation _____
SS# _____
DL# _____ Birthdate _____

Marital Status Single Married Divorced
 Widowed Separated

FATHER Stepfather Guardian

Name _____
Home Phone _____
Work Phone _____ Ext. _____
Employer _____
Occupation _____
SS# _____
DL# _____ Birthdate _____

Marital Status Single Married Divorced
 Widowed Separated

PRIMARY INSURANCE

Insured's Name _____
Relationship to Patient _____
Birthdate _____ SS# _____
Employer _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City, State, Zip _____
Ins. Co. Phone _____

Who is Accompanying the Child Today? Name _____ Relationship _____

ADDITIONAL INSURANCE

Insured's Name _____
Relationship to Patient _____
Birthdate _____ SS# _____
Employer _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City, State, Zip _____
Ins. Co. Phone _____

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 - Visa MasterCard Discover

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child take fluoride supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child:	
Suck thumb/finger <input type="checkbox"/> Yes <input type="checkbox"/> No	Chew hard objects (pencils, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
Suck/Bite lip <input type="checkbox"/> Yes <input type="checkbox"/> No	Grind teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
Bite/Chew nails <input type="checkbox"/> Yes <input type="checkbox"/> No	Clench jaws <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous dentist _____	Address _____
Date of last dental visit? _____	
Has your child had difficulty with previous dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Physician _____	Address _____
Physician Phone # _____	
Previous Hospitalizations/Surgeries/Serious Illnesses? _____	When? _____
_____	_____
_____	_____
Is your child currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? Yes No (if yes, please describe) _____

Has your child ever had any of the following:	Convulsions/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach, liver or kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Signature of parent or guardian

Date

Signature of Dentist

Date