Welcome

Patient ID# _____ Today's Date _____

to our practice! We strike to make each of your child's visits please and comfortable. Please fill out the form completely.

Your Child

Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____ SSN: _____

School _____ Grade _____

Address _____

City _____ State ___ ZIP _____

Home Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State ___ ZIP _____

Email _____

TDL# _____ SSN: _____

Home Phone _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Best time to call

Time _____ Days _____

Time _____ Days _____

Mother

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Email _____

Employer _____

Occupation _____

SSN: _____ TDL# _____

City _____ State ___ ZIP _____

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

Father

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Email _____

Employer _____

Occupation _____

SSN: _____ TDL# _____

City _____ State ___ ZIP _____

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

Primary Insurance

Name of Insured _____

Relationship _____

Birthdate _____ SSN: _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group# _____ Employee # _____

Ins. Co. Address _____

City _____ State ___ ZIP _____

Deductible _____ Copay _____

Amount Already Used _____

Max. Annual Benefit _____

Secondary Insurance

Name of Insured _____

Relationship _____

Birthdate _____ SSN: _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group# _____ Employee # _____

Ins. Co. Address _____

City _____ State ___ ZIP _____

Deductible _____ Copay _____

Amount Already Used _____

Max. Annual Benefit _____

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 ☐ Visa ☐ MC ☐ I wish to discuss dental office's payment policy

Dental & Health History

CONFIDENTIAL

Patient ID# _____

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

	Y	N		Y	N
How often does your child brush _____			How often does your child floss _____		
Is your child's water fluoridated	☐	☐	Does your child take fluoride supplements	☐	☐
Does your child:			Chew hard objects	☐	☐
Suck thumb/finger	☐	☐	Grind teeth	☐	☐
Suck/bite lip	☐	☐	Clench jaws	☐	☐
Bite/chew nails	☐	☐			

Previous dentist _____ Child's physician _____

Date of last dental visit _____ Phone _____

Address _____ Address _____

City _____ State ___ ZIP _____ City _____ State ___ ZIP _____

Has your child had difficulty with previous dental visits ☐ ☐

Previous Hospitalizations, Surgeries or Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking any medications ☐ ☐

If yes, please list _____

Has your child ever taken Fen-Phen or Redux ☐ ☐

Does your child have a history any allergies, sensitivities or adverse reactions to any drugs or medications (penicillin, Novacain, etc.) ☐ ☐

If yes, please list _____

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

If yes, please list _____

Has your child ever had the following:	Y	N		Y	N
Asthma	☐	☐	Stomach, liver or kidney problems	☐	☐
Cancer	☐	☐	Handicaps / Disabilities	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
HIV / AIDS	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Rheumatic Fever	☐	☐
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐	Congenital Heart Defect	☐	☐
			Heart Murmur	☐	☐
Heart Surgery	☐	☐	Convulsions / Epilepsy	☐	☐

Describe any other medical problems _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions 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 status. I also authorize the dental staff to perform the necessary dental services my child may need.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pass 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 Review:

_____ _____

Signature of Dentist Date

Print Form