WELCOME

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS# / SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____

Phone _____ SS#/ SIN _____

DL# _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Day _____

_____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

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

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

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

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

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 ☐ MC ☐ Discover ☐ AMEX

☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship 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	Grind teeth	☐ Yes ☐ No
Suck/Bite lip	☐ Yes ☐ No	Clench jaws	☐ Yes ☐ No
Bite/Chew nails	☐ Yes ☐ No	Gag easily	☐ Yes ☐ No
Chew hard objects (pencils, etc.)	☐ Yes ☐ No	Tonsils/Adenoids removed _____ age	☐ Yes ☐ No
		Speech Problem	☐ 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 Illnesses? 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 substances (latex, environmental, etc.)? ☐ Yes ☐ No

_____

Has your child ever had any of the following:

Acid Reflux	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Describe _____	
Asthma	☐ Yes ☐ No		
Blood Transfusion	☐ Yes ☐ No	Hemophilia/Abnormal Bleeding	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Convulsions/Epilepsy	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Persistent cough	☐ Yes ☐ No
Food Allergies	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Handicaps/Disabilities	☐ Yes ☐ No	Stomach, liver or kidney problems	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Please explain any medical problem that your child has: _____

_____

Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, 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 Review

_____ _____

Signature of Dentist Date