thank you for selecting us.

Patient ID # _____

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_____ Social Security # _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City, State, Zip _____ Phone _____

Responsible Party

Name _____ Relationship_____

Address _____

City, State, Zip _____ Phone _____

Social Security #_____ DL#_____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name_____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ DL # _____

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

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name_____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ DL # _____

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

Primary Insurance

Insured's Name _____ Relationship_____

Birthdate_____ Social Security #_____

Employer_____ Date Employed _____ Occupation _____

Insurance Co._____Group #_____ Employee #_____

Ins. Co. Address_____ City_____ State_____ Zip _____

Deductible_____ Copay_____ Amount already used_____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship_____

Birthdate_____ Social Security #_____

Employer_____ Date Employed _____ Occupation _____

Insurance Co._____ Group #_____ Employee #_____

Ins. Co. Address_____City_____ State_____ Zip _____

Deductible_____ Copay_____ Amount already used_____ Max. annual benefit _____

Over Please

Dental/Medical Health History (Confidential)

Patient ID #_____

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? _____

Child attitude to dentistry _____

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

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

Do you desire complete dental service for the child _____ ☐ Yes ☐ No

Date of Last Dental Visit _____

For what service _____

Previous Dentist _____

Address _____

Has child complained about dental problems_____ ☐ Yes ☐ No

Any injuries to mouth - teeth - head _____ ☐ Yes ☐ No

Any unusual speech habits _____ ☐ Yes ☐ No

Any lost teeth _____ ☐ Yes ☐ No

Have missing teeth been replaced_____ ☐ Yes ☐ No

Orthodontic appliances worn now or ever been_____ ☐ Yes ☐ No

Do you assist child with tooth brushing ☐ Yes ☐ No

How often _____

Is dental floss used ☐ Yes ☐ No

How often _____

Are disclosing tablets used _____ ☐ Yes ☐ No

Has your child ever had any of the following:

Abnormal Bleeding	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Malignancies	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mastoid	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Measles	☐ Yes	☐ No
Bladder	☐ Yes	☐ No	Handicaps/Disabilities	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hearing	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Heart	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Chronic Sinus	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No	Veneral Disease	☐ Yes	☐ No
						Other	☐ 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 your prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Authorization and 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 Guardian, if minor Date

Dentist's Review: _____

_____

_____

_____

_____

_____

Signature of Dentist Date