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 _____ Best time to call _____

Home Phone _____ Cell Phone _____ Time _____ Day _____

Work Phone _____ Ext. _____

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.

Denta. & 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? _____

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