



We are pleased to welcome you & your child to our practice. Please take a few minutes to fill out this form . If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Full Name of Minor/Child _____ Sex M F Age _____

Nickname _____ Hobbies _____ Cell Phone _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone _____

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

<p>Father's /Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small></p> <p>E-mail _____</p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____ Phone _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p> <p>Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Mother's /Guardian's Name _____</p> <p>Address (if different from patient's) _____</p> <p>Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small></p> <p>E-mail _____</p> <p>Employer _____</p> <p>Soc. Sec. # _____ Birthdate _____</p> <p>Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan Name _____ Phone _____</p> <p>Address _____</p> <p>Group # _____ Policy # _____</p> <p>Child's Medical Assistance I.D. # _____</p>
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DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

Has child complained about dental problems? Yes No Is fluoride taken in any form? Yes No

Does child brush teeth daily? Yes No Any injuries to mouth, teeth, head? Yes No

Does child use floss every day? Yes No Any unhappy dental experiences? Yes No

Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? Yes No

Patient name _____

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now?..... Yes No Medications _____

Receiving any medication or drugs? Yes No _____

Ever been hospitalized? Yes No Allergies _____

Ever had surgery? Yes No _____

Is there excessive bleeding when cut? Yes No _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | | | | <input type="checkbox"/> Other |

EMERGENCY

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____ and assign directly
Name of Insurance Company(ies)

to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____