Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have 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 ______________

Name of Minor/Child ______________ (Last Name) ______________ (First Name) ______________ (Middle Initial) 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

Father's / Guardian's Name ______________

Address (if different from patient's) ______________

Home Phone (____) ______________ (if different from above) Work Phone (____) ______________ (if different from above)

E-mail ______________

Employer ______________

Soc. Sec. # ______________ Birthdate ______________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______________ Phone (____) ______________

Address ______________

Group # ______________ Policy # ______________

Mother's / Guardian's Name ______________

Address (if different from patient's) ______________

Home Phone (____) ______________ (if different from above) Work Phone (____) ______________ (if different from above)

E-mail ______________

Employer ______________

Soc. Sec. # ______________ Birthdate ______________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______________ Phone (____) ______________

Address ______________

Group # ______________ Policy # ______________

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # ______________

DENTAL HISTORY

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

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications _____
Receiving any medication or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies _____
Is there excessive bleeding when cut?	☐	☐	_____

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

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

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 to
Name of Insurance Company(ies)

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

UPDATE

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 _____