Today's Date ______________

Welcome

to our practice! 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 ______________
Nickname ______________ Sex ______
Birthdate ______________ Age ______
SS # ______________
School ______________ Grade ______
Child's Home Address ______________
City ______________ State ______ Zip ______
Phone ______________

Responsible Party (Financial)

Name ______________
Relationship ______________
Address ______________
City ______________ State ______ Zip ______
E-Mail ______________
SS # ______________

Who is responsible for making appointments?

Name ______________
Home Phone ______________ Cell Phone ______________
Work Phone ______________ Ext. ______
Best time to call ______________
Time ______________ Days ______________
Relation to Child ______________

Mother ☐ Stepmother ☐ Guardian

Name ______________
Home Phone ______________ Cell Phone ______________
Work Phone ______________ Ext. ______
E-Mail ______________
Employer ______________
Occupation ______________
SS # ______________

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

Father ☐ Stepfather ☐ Guardian

Name ______________
Home Phone ______________ Cell Phone ______________
Work Phone ______________ Ext. ______
E-Mail ______________
Employer ______________
Occupation ______________
SS # ______________

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

Primary Insurance

Insured's Name ______________
Relationship ______________
Birthdate ______________ SS # ______________
Employer ______________ Date Employed ______________
Occupation ______________
Insurance Company ______________
Group # ______________ Employee # ______________
Ins. Co. address ______________
City ______________ State ______ Zip ______
Deductible ______________ Copay ______________
Amount already used ______________
Max. annual benefit ______________

Additional Insurance

Insured's Name ______________
Relationship ______________
Birthdate ______________ SS # ______________
Employer ______________ Date Employed ______________
Occupation ______________
Insurance Company ______________
Group # ______________ Employee # ______________
Ins. Co. address ______________
City ______________ State ______ Zip ______
Deductible ______________ Copay ______________
Amount already used ______________
Max. annual benefit ______________

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 ☐ I wish to discuss the office's payment policy

Child Dental & Health History *CONFIDENTIAL*

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	Chew hard objects (pencils, etc.)	☐ Yes	☐ No
Suck/Bite lip	☐ Yes	☐ No	Grind teeth	☐ Yes	☐ No
Bite/Chew nails	☐ Yes	☐ No	Clench jaws	☐ 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 Illness? 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 substance (latex, environmental, etc.)?

____

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No	Stomach, liver or kidney problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Handicaps/Disabilities	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No
			Heart Murmur	☐ Yes	☐ No
			Convulsions/Epilepsy	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No			

Please explain any medical problems that your child has: ______________

____

Authorization & 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 parent if minor Date

Dentist Review:

______________ ______________

Signature of Dentist Date