WELCOME

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.

Child Information (CONFIDENTIAL)

Today's Date_____

Child's Name_____ Nickname_____

Birthdate_____ Age_____ SS#_____

School_____ Grade_____

Child's Home Address_____

City_____ State_____ Zip_____ Phone_____

Responsible Party

Name_____ Relationship to patient_____

Address_____ City_____ State_____ Zip_____

E-mail_____ SS#_____

Mother (❑ Stepmother ❑ Guardian)

Name_____ Birthdate_____ SS#_____

Address_____

City_____ State_____ Zip_____ Phone_____

E-mail address_____ Work phone_____ Cell phone_____

Employer_____ Occupation_____

Marital status ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Father (❑ Stepfather ❑ Guardian)

Name_____ Birthdate_____ SS#_____

Address_____

City_____ State_____ Zip_____ Phone_____

E-mail address_____ Work phone_____ Cell phone_____

Employer_____ Occupation_____

Marital status ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Primary Dental Insurance Information

Name of Insured_____ Relationship to patient_____

Birthdate_____ SS#_____

Employer_____ Occupation_____

Address of Employer_____

Insurance Company_____ Group Number_____

Insurance Co. Address_____ Ins. Co. Phone Number_____

City_____ State_____ Zip_____ Phone_____

Brian E. Woodard, D.D.S., Inc.
Comprehensive Family Dentistry
3330 Park Street, Suite B • Grove City, OH 43123 • 614.875.9500 614.879.6086 (home) • Email: bwoodard@rrohio.com • Web: bwoodarddds.com

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ❑ Yes ❑ No

If yes, please complete the following:

Name of Insured_____ Relationship to patient_____

Birthdate_____ Social Security Number_____

Name of Employer_____

Address of Employer_____

Insurance Company_____ Group Number_____

Insurance Co. Address_____ Ins. Co. Phone Number_____

Dental and Health History - CONFIDENTIAL

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?_____ Floss?_____

Previous dentist_____ Address_____

Date of last dental visit_____ Do any of your child's teeth hurt?_____

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

Is your child currently taking medications? ❑ Yes ❑ No

If yes, please list _____

Child's physician_____ Phone #_____

Previous Hospitalization/Surgeries/Serious Illnesses? ❑ Yes ❑ No When?_____

Does your child have any allergies (latex, environmental, etc.)? ❑ Yes ❑ No

If yes, please describe _____

Please explain any medical problems that your child has:

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
Abnormal bleeding	❑ Yes	❑ No	Congenital heart defect	❑ Yes	❑ No
Heart murmur	❑ Yes	❑ No	Epilepsy/Convulsions	❑ Yes	❑ No

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 any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental 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.

X_____

Signature of parent/guardian