WELCOME!

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. To help us meet all your dental needs, please fill out this form completely.

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# _____

Who should we contact to confirm or change appointments? _____ PHONE _____

MOTHER (☐ STEPMOTHER ☐ GUARDIAN)

NAME _____ BIRTHDATE _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

FATHER (☐ STEPFATHER ☐ GUARDIAN)

NAME _____ BIRTHDATE _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

EMPLOYER _____ OCCUPATION _____

ADDRESS OF EMPLOYER _____

INSURANCE COMPANY _____ GROUP NUMBER _____

INSURANCE CO. ADDRESS _____ INSURANCE CO. PHONE NUMBER _____

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 _____ INSURANCE 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? _____

Are you interested in straightening your child's teeth? Any other concerns? _____

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 Hospitalizations / 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 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	Scarlet fever	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Congenital heart defect	☐ 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 dentist 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 record of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to thee 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 the payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PARENT OR GUARDIAN _____