Welcome

Please complete front and back and bring with you to your appointment

TELL US ABOUT YOUR CHILD

Patient's Name_____

Date of Birth:_____ Age:_____

Nickname:_____ M☐ F☐

Physical Address:_____

Mailing Address:

City, State Zip:

Home Phone:

Do you have legal custody of this child?

☐ Yes ☐ No

In case of an emergency, please call:

Name:

_____

Phone:

_____

Other family members seen by us:

Name and phone # of nearest relative not living with you:

FATHER'S INFORMATION

☐ Married ☐ Single

☐ Guardian ☐ Step

Name:_____

Social Security #:_____

Date of Birth:_____

Employer: Work Ph:

Home Phone: Cell Phone:

Email Address:_____

MOTHER'S INFORMATION

☐ Married ☐ Single

☐ Guardian ☐ Step

Name:_____

Social Security #_____

Date of Birth:

_____

Employer: Work Ph:

_____

Home Ph:_____ Cell Phone:_____

Email Address:_____

I have reviewed the following treatment plan and fee. I agree to be responsible for all charges for dental service and materials not paid by my dental benefit plan, unless their treating dentist or dental practices has a contractors agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claims.

Signature of parent or guardian Date

PERSON RESPONSIBLE FOR ACCOUNT

Name:

Relation:

Mailing Address:

Home Phone: Work Phone:

Alt Phone#:

Who may we thank for referring you?

☐ Patient ☐ Doctor ☐ Other

Name:

Address:

Phone #:

INSURANCE INFORMATION:

Insured's Name

Insured's Date of Birth:

Insured's Social Security #:

Relationship to Patient:

Employer:

Employer Phone:

Insurance Co. Name:

Group:(Plan, Local, or Policy

I understand that responsibility for payment for Dental Service provided for my dependents is mine due and payable at the time services are rendered unless prior arrangements have been made.

Signature of parent or guardian Date

MEDICAL HISTORY

Previous/Present Dentist_____
Child's Physician_____

Phone # _____Date of Last Visit _____

Is this child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health.

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently Taking_____
_____
_____

Please list all drugs that the child is allergic to

_____
_____
_____
_____

Does the child have any of the following habits?

Yes	No	
☐	☐	Thumb/Finger Sucking
☐	☐	Lip Sucking/Biting
☐	☐	Nail Biting
☐	☐	Nursing/Bottle Habits
☐	☐	Mouth Breathing
☐	☐	Nighttime Grinding of Teeth

Does your child have a Heart Condition?

☐ Yes ☐ No

Explain:_____
_____

If yes, Child's Cardiologist and phone #:
_____
_____

Does the child have/or ever had any of the following medical problems?

Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	Convulsions/Epilepsy
☐	☐	Diabetes	☐	☐	Abnormal Bleeding
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment
☐	☐	HIV+/AIDS	☐	☐	Any Operations
☐	☐	Hemophilia	☐	☐	Any Hospital Stays
☐	☐	Asthma	☐	☐	Kidney/Liver Problems
☐	☐	Hepatitis	☐	☐	Handicaps/Disabilities
☐	☐	Tuberculosis (TB)	☐	☐	Allergies
☐	☐	Chronic upper respiratory problems	☐	☐	Pregnant

Please discuss any serious medical problems that the child has had

_____
_____
_____

What is the reason for today's visit?

_____
_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the doctors and dental staff to perform any necessary dental services my child may need.

Signature of parent or guardian Date

Signature of person accompanying child Date