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 _____

Name of Minor/Child _____
LAST FIRST MID.INIT.

Sex ☐ M ☐ F Age _____ Birth date _____ Nickname _____ Hobbies _____

Home Address _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

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)

Employer _____

Soc. Sec. # _____ Birth date _____

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

Plan Name _____

Phone Number _____

Address _____

Group # _____ Policy # _____

Is you child eligible for treatment under Medical Assistance? ☐ Yes ☐ No

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birth date _____

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

Plan Name _____

Phone Number _____

Address _____

Group # _____ Policy # _____

Is you child eligible for treatment under Medical Assistance? ☐ Yes ☐ No

DENTAL HISTORY

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

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ☐ ☐

Please Complete Both Sides

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?	☐	☐
Receiving any medications or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

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 _____

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand 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 authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____ Date _____

I certify that my minor/child is covered by insurance with:

_____

Name of Insurance Company(ies)

and assigned directly to 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian _____

AUTHORIZATION

I give my consent for any advisable and necessary dental procedures, medications or anesthetics to be administered by the dentist or by his supervised staff for diagnostic purposes or dental treatment.

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: _____

Signature of Parent/Guardian _____ Date _____

Dentist Signature _____ Date _____

Please Complete Both Sides