



Welcome

We look forward to working with you in maintaining your child's dental health. Please take a few minutes to fill out this form.

Patient Information

Date _____ SS/HIC/Patient ID# _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____

Last First Middle initial

Nickname _____ Cell Phone _____

Home Address _____

Street City State Zip

Mailing Address _____

Street City State Zip

School Name _____ School Phone _____

Person Financially Responsible _____ Home Phone _____

Work Phone _____ Whom may we thank for referring you? _____

Insurance

Father's/Guardian's Name _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Address (if different from patient's) _____

Home ph. _____ Work ph. _____

Home ph. _____ Work ph. _____

Email _____

Email _____

Employer _____

Employer _____

SSN _____ Birthdate _____

SSN _____ Birthdate _____

Do you have dental ins. coverage for minor/child? _____

Do you have dental ins. coverage for minor/child? _____

Plan Name _____ Phone _____

Plan Name _____ Phone _____

Address _____

Address _____

Group# _____ Policy # _____

Group# _____ Policy# _____

Is your child eligible for treatment under Medical Assistance? _____ Child's Medical Assistance ID # _____

Dental History

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

Has child complained about dental problems? Y N Does child brush teeth daily? Y N

Does child use floss every day? Y N Is fluoride taken in any form? Y N

Any injuries to mouth, teeth, head? Y N Any unhappy dental experiences? Y N

Any mouth habits—thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? Y N

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Medical History

Child's Physician _____ City/State _____ Phone _____
Date of last physical examination _____ Results _____
Is minor/child under care of physician now? Y N Medications _____
Receiving any medication or drugs? Y N _____
Ever been hospitalized? Y N Allergies _____
Ever had surgery? Y N _____
Is there excessive bleeding when cut? Y N _____

Has minor/child had any history of or difficulty with any of the following? If yes, please circle.

A.I.D.S./H.I.V	Cerebral Palsy	Epilepsy	Kidney Disease
Rheumatic Fever	Anemia	Chicken Pox	Fainting
Liver Disease	Sinus Problems	Asthma	Bladder Problems
Cancer	Convulsions	Diabetes	Drug/Alcohol Abuse
Hearing problems	Heart problems	Hepatitis	Measles
Mononucleosis	Mumps	Thyroid Disease	Tuberculosis
Other			

Emergency Contact

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Authorizations

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

I am the parent, guardian or personal representative of _____
Please print name of minor/child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company (ies)

and assign 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my child's health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

Signature of Parent, Guardian or Personal Representative

Date

Please Print name of Parent, Guardian or Personal Representative

Relationship to Patient