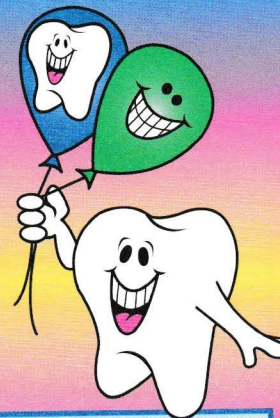


Welcome!

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 _____ SS/HIC/Patient ID # _____ Birthdate _____
Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name _____ First Name _____ Middle Initial _____
Nickname _____ Hobbies _____ Cell Phone (____) _____
Home Address _____
Street _____ City _____ State _____ Zip _____
Mailing Address _____
Street _____ City _____ State _____ Zip _____
School Name _____ School Phone (____) _____
Person financially responsible _____ wwPhone (____) _____ Work Phone (____) _____
Whom may we thank for referring you? _____

INSURANCE

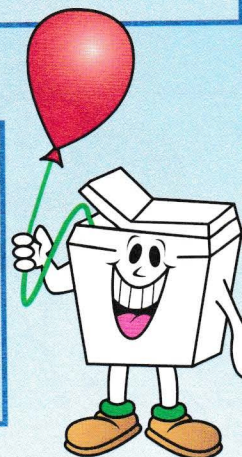
Father's/Guardian's Name _____
Address (if different from patient's) _____
Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)
E-mail _____
Employer _____
Soc. Sec. # _____ Birthdate _____
Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No
Plan Name _____ Phone (____) _____
Address _____
Group # _____ Policy # _____

Mother's/Guardian's Name _____
Address (if different from patient's) _____
Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)
E-mail _____
Employer _____
Soc. Sec. # _____ Birthdate _____
Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No
Plan Name _____ Phone (____) _____
Address _____
Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____	For what service? _____
Has child complained about dental problems? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is fluoride taken in any form? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does child brush teeth daily? <input type="checkbox"/> YES <input type="checkbox"/> NO	Any injuries to mouth, teeth, head? <input type="checkbox"/> YES <input type="checkbox"/> NO
Does child use floss every day? <input type="checkbox"/> YES <input type="checkbox"/> NO	Any unhappy dental experiences? <input type="checkbox"/> YES <input type="checkbox"/> NO
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> YES <input type="checkbox"/> NO	



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?	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
Receiving any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- | | | | | |
|-------------------------------------------|---------------------------------------------|-------------------------------------------|-----------------------------------------|------------------------------------------|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> 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.

Minor/Child Consent

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.

Insurance Assignment and Release

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

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.

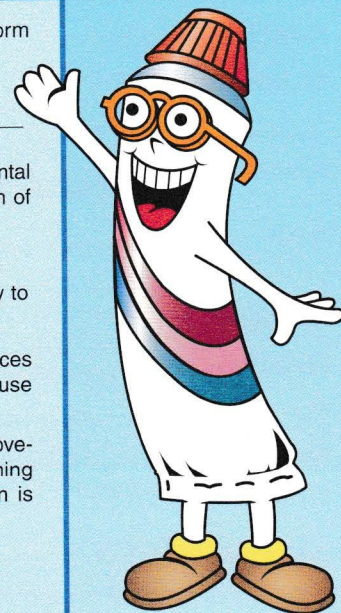
The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This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

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient



UPDATE

TO BE COMPLETED AT LATER VISIT

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 _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

