

# 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 any 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/Patient ID # \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Minor \_\_\_\_\_ Sex \_\_\_M\_\_\_F Age \_\_\_\_\_  
Last First Middle Initial

Nickname \_\_\_\_\_ Hobbies \_\_\_\_\_ Child's 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 (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

## INSURANCE

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____ _____	Address (if different from patient's) _____ _____
Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above)	Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above)
E-Mail _____	E-Mail _____
Employer _____	Employer _____
SS# _____ Birthdate _____	SS# _____ Birthdate _____
Do you have dental insurance coverage for minor ___Yes ___No	Do you have dental insurance coverage for minor ___Yes ___No
Plan Name _____ Phone (____) _____	Plan Name _____ Phone (____) _____
Address _____	Address _____
Group# _____ Policy# _____	Group# _____ Policy# _____
Is your child eligible for treatment under medical assistance? ___Yes___No	Child's Medical Assistance ID# _____

## DENTAL HISTORY

Date of last visit to a dentist _____	For what service? _____
Has child complained about dental problems? ___Yes ___No	Is fluoride taken in any form?..... ___Yes___No
Does child brush teeth daily?..... ___Yes ___No	Any injuries to mouth, teeth, head?..... ___Yes___No
Does child use floss every day?..... ___Yes ___No	Any unhappy dental experiences?..... ___Yes___No
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?..... ___Yes___No	

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## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

Is Child under care of physician now?..... Yes \_\_\_ No \_\_\_ Medications \_\_\_\_\_

Receiving any medications or drugs?..... Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Ever been hospitalized? ..... Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Ever had surgery? ..... Yes \_\_\_ No \_\_\_ Allergies \_\_\_\_\_

Is there excessive bleeding when cut?..... Yes \_\_\_ No \_\_\_ \_\_\_\_\_

Has minor/child had any history of or difficulty with any of the following? If yes please (x)

<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 completed or three years from the date signed below.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient