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_____

Address (if different from patient's)_____

_____

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

E-Mail_____

Employer_____

SS#_____ Birthdate_____

Do you have dental insurance coverage for minor ___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_____

SS#_____ Birthdate_____

Do you have dental insurance coverage for minor ___Yes ___No

Plan Name_____ Phone (___)_____

Address_____

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

---OVER----

MEDICAL HISTORY

Child's Physician_____ City/State_____ Phone (____)_____

Date of last physical examination_____ Results_____

Is Child under care of physician now?....._____Yes _____No

Receiving any medications or drugs?....._____Yes _____No

Ever been hospitalized? ……_____Yes _____No

Ever had surgery? ……_____Yes _____No

Is there excessive bleeding when cut?....._____Yes _____No

Medications_____

_____

_____

Allergies_____

_____

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

___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 (____)_____

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 hearby 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

Christine M. Saad DDS PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-248-693-5844.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم –(248-693-5844) رقم .:والبكم الصم ه