W E L C O M E

WE are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form and 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/HIC/Patient ID #___________________ Birthdate______________ Age ________ Sex ☐ M ☐ F

Name of Minor/ Child ____

Last Name First Name Middle Initial

Nickname______________________ Hobbies________________________ Cell phone ( ) ________-__________

Home Address ____

School Name____ School phone ( ) _____- ____________

Person financially responsible_________________ Home phone ( ) _____- _________ Work Phone ( ) _____- _________

Who may we thank for referring you? ____

INSURANCE

Father's/ Guardian's Name _____________________________

Address (if different from patient's)_____________________

____

Home phone( ) ________ Work Phone ( ) _________

E-MAIL____

Employer ____

SSN# _____________________Birthdate ________________

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

Plan name_______________ Phone number ( )__________

Address ____

Group #_________________ Policy #_____________________

Mother's/ Guardian's Name _____________________________

Address (if different from patient's)_____________________

____

Home phone( ) ________ Work Phone ( ) _________

E-MAIL____

Employer ____

SSN# _____________________Birthdate ________________

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

Plan name_______________ Phone number ( )__________

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

Does your child brush daily? ☐ Yes ☐ No

Does your child use floss daily? ☐ Yes ☐ No

Is fluoride taken in any form ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any unhappy dental experiences? ☐ Yes ☐ No

Any mouth habbits- thumbsucking, nail biting, mouth breathing, sleeping with bottle, etc? ☐ Yes ☐ No

MEDICAL HISTORY

Minor's/ child's Physician__________________________ City/ State_____________________ Phone number (   )_____________

Date of last physical examination ________________________ Results ____

Is minor under care of physician now ☐ Yes ☐ No

Receiving any medications? ☐ Yes ☐ No

Ever been hospitalized? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No

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 check ( )

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

EMERGENCY CONTACT

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

Name ______________________________ Relationship _______________________________ Phone (   )____________________

Name ______________________________ Relationship _______________________________ Phone (   )____________________

AUTHORIZATION

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 ____

And there are no court orders now in effect that prohibit me from signing this consent. I do herby request and authorize the dental staff to perform necessary dental serv ices for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether 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 Dr.______________________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether 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 payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

____
Signature of the Parent, Guardian, or Personal Representative

____
Date

____
Please print name of Parent, Guardian or Personal Representative

____
Relationship to Patient