

W E L C O M E

WE are pleased to welcome you and your teen 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 <input type="checkbox"/> M <input type="checkbox"/> F
Name of Minor _____				
	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 _____	Mother's/ Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home phone() _____ Work Phone () _____	Home phone() _____ Work Phone () _____
E-MAIL _____	E-MAIL _____
Employer _____	Employer _____
SSN# _____ Birthdate _____	SSN# _____ Birthdate _____
Do you have dental coverage for minor/ child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental coverage for minor/ child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan name _____ Phone number () _____	Plan name _____ Phone number () _____
Address _____	Address _____
Group # _____ Policy # _____	Group # _____ Policy # _____
Is your child eligible for treatment under Medical Assistance ? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's Medical Assistance ID # _____	

DENTAL HISTORY

Date of last visit to a dentist _____	For what service? _____
Do you brush daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you floss daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is fluoride taken in any form	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any injuries to mouth, teeth, head?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any unhappy dental experiences?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any mouth habits-, nail biting, mouth breathing, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Cerebral Palsy

Epilepsy

Kidney Disease

Rheumatic Fever

Asthma

Chicken Pox

Fainting

Liver disease

Sinus Problems

Bladder Problems

Convulsions

Hearing problems

Measles

Thyroid problems

Cancer

Diabetes

Heart problems

Mononucleosis

Tuberculosis

Drug/ Alcohol abuse

Hepatitis

Mumps

Other

EMERGENCY CONTACT

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

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 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 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