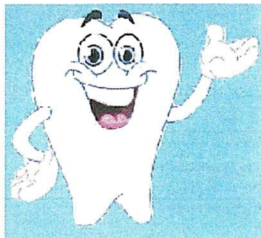
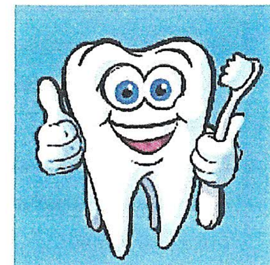


Welcome!



We are please 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

Today's Date_______________ 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 _______________

Home Phone(____) _______________ Work Phone(____)_______________

Whom may we thank for referring you?_______________

Father's/Guardian's Name_______________

Address (if different from patient's)_______________

____

Home Phone(____)_______ Work Phone(___)_______________

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(___)_______________

E-mail_______________

Employer_______________

Soc. Sec. #_______________

Birthdate: _______________

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

Plan Name_______________ Phone(____)_______________

Address_______________

Group #_______________ Policy #_______________

DENTAL HISTORY

Date of last visit to a dentist_______________

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits- thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

Last dental cleaning? _______________ Last dental exam_______________

Last dental x-rays? BW_______________ Panoramic/FMX_______________

Last fluoride treatment taken?_______________ Last sealant Placement?_______________

MEDICAL HISTORY

Minor/Child's Physcian____________________ City/State____________________ Phone(____)__________

Date of last Physical examination____________________ Results____________________

Is Minor/Child under care of physician now? .... ☐YES ☐ NO

Receiving any medication 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 check (√).

☐ A.I.D.S./H.I.V.	☐ Anemia asthma	☐ Bladder Problems	☐ Cancer	☐ Cerebral Palsy
☐ Chicken Pox	☐ Convulsions	☐ Diabetes	☐ Drug/Alcohol Abuse	☐ Epilepsy
☐ Fainting	☐ Hearing Problems	☐ Hepatitis	☐ Kidney Disease	☐ Liver Disease
☐ Measles	☐ Mononucleosis	☐ Mumps	☐ Rheumatic Fever	☐ Sinus Fever
☐ Thyroid Disease	☐ Tuberculosis	☐ 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 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 one year 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