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 questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Phone _____

Sex ☐M ☐F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Child _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from child)* _____ Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to child _____ Birthdate _____

Address *(if different from child)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ☐ Y ☐ N

Has your child ever experienced a mouth or chin injury? ☐ Y ☐ N

Does your child have speech problems? _____

Have your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N

Other information about your child's dental health or previous treatment _____

_____

Medical History

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? ☐ Y ☐ N

If yes, describe _____

Is your child currently under physician care? ☐ Y ☐ N If yes, describe _____

Has your child ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____

Has your child ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Y ☐ N

Check (✓) if your child has had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Blood disease
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart problems Describe _____
- ☐ Hemophilia/ Abnormal bleeding
- ☐ Immunizations current
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (**latex**, wool, metal, chemicals)
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Thyroid disease or malfunction
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other _____

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.