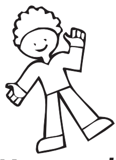
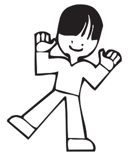


Welcome To Our Office!



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 ______________________________ Nickname ______________

Age _______ Date of Birth ______________________ Sex: ❑ M ❑ F Place of Birth ______________

Social Security # ______________ Grade _______ School ______________

Child's Address ______________________________ Phone ______________

City, State, Zip ______________________________

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

Please indicate the FINANCIALLY RESPONSIBLE PERSON: Self: ________ Mother ________ Father ________

The responsibility of payment is assumed by the parent/person who brings the child in for their appointment.

Mother's Name ______________________ Birthdate ___________ Soc. Sec. No. ___________

Occupation ______________________ Firm ______________________

Business Address ______________________________ Bus. Phone ______________

Home Address ______________________________ Home Phone ______________

Cell Phone ______________

Father's Name ______________________ Birthdate ___________ Soc. Sec. No. ___________

Occupation ______________________ Firm ______________________

Business Address ______________________________ Bus. Phone ______________

Home Address ______________________________ Home Phone ______________

Cell Phone ______________

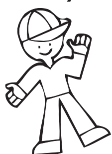
Other children in the family:

Name ______________________ Age ______ Name ______________________ Age ______

Name ______________________ Age ______ Name ______________________ Age ______

Name ______________________ Age ______ Name ______________________ Age ______

Who referred you to our office? Name ______________________________



Address ______________________________

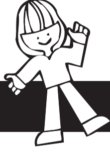
____

Dental Insurance Information

Dental Health Insurance ❑ Y ❑ N

If yes, please specify carrier (Primary) ____________________

(Secondary) ____________________



Primary Dental Insurance

Subscriber's Name ____________________
Last Name *First Name* *Initial*

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

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

City ____________ State ____________ Zip ____________

Employer Name ____________________

Business Address ____________ Business Phone ____________

Insurance Company ____________ Phone ____________

Contract # ____________ Group # ____________ Subscriber ID# ____________

Is child covered by additional insurance? ❑ Y ❑ N *If yes, complete section below. If no, skip to insurance authorization*

Secondary Dental Insurance

Subscriber's Name ____________ Relation to Child ____________ Birthdate ____________

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

City ____________ State ____________ Zip ____________

Employer Name ____________________

Business Address ____________ Business Phone ____________

Insurance Company ____________ Phone ____________

Contract # ____________ Group # ____________ Subsciber ID# ____________

Insurance Authorization

I authorize the insurance company(s) indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize 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 ____________

Copayments (out of pocket expenses) are expected to be paid at the time of service.
For your convenience, we gladly accept payment in the form of cash, check or MasterCard/Visa/Discover/American Express cards.

Medical History

Child's Physician ______________________ Phone (____) ______________________

Address ______________________ City ____________ State ________ Zip ________

Does Child have or ever had any of the following diseases or medical conditions?

Heart Murmur	Y	N	Tonsillitis	Y	N	High/Low Blood Pressure	Y	N
Rheumatic Fever	Y	N	Respiratory Problems	Y	N	Hepatitis	Y	N
Artificial Heart Valves	Y	N	Asthma	Y	N	Artificial Bones/Joints/Implants	Y	N
Congenital Heart Defect	Y	N	Difficulty Breathing	Y	N	Organ Problems	Y	N
Scarlet Fever	Y	N	Leukemia	Y	N	HIV+/AIDS/ARC	Y	N
Surgeries/Operations	Y	N	Anemia	Y	N	Tuberculosis TB	Y	N
Cancer/Tumors	Y	N	Diabetes/Hypoglycemia	Y	N	Psychiatric Problems	Y	N
Chemotherapy	Y	N	Hemophilia	Y	N	Hyper Active/ADD	Y	N
Jaw Problems TMJ/TMD	Y	N	Abnormal Bleeding	Y	N	Fainting/Seizures/Epilepsy	Y	N

Please list any other medical condition(s) child has or ever had: ______________________

____

Is Child allergic to: (Please circle all that apply)

Latex   Tetracycline   Aspirin

Penicillin/Amoxicillin   Anesthetics   Food Allergies

Other(s) (Please explain) ______________________

Is your child taking any medication(s) at the present time   Y   N

If yes, please specify ______________________

Does your child have a physical disorder such as poor coordination, cerebral palsy or problems of vision, hearing or speech   Y   N

If yes, please elaborate ______________________

Does your child have a history of mental retardation, brain damage, psychological or emotional problems   Y   N

If yes, please elaborate ______________________

Does your child require antibiotic premedication for dental treatment?   Y   N

Dental History

Is this your chld's first dental visit? (please circle one) Yes No

What brings you to our office today? ______________________________

How often does your child brush? ____________________ Floss? ____________________

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

Does your child have any of the following habits? (check all that apply)

❑ bottle at bedtime ❑ pacifier or thumb sucking ❑ finger or lip sucking ❑ teeth grinding ❑ mouth breathing
❑ tongue thrust ❑ tobacco use

Please describe your child's personality: ______________________________

____

____

Medical/Dental History Updates

____ / ____ (Parent DDS Initials) ____ / ____ / ____ (Date) ______________________________

____ / ____ (Parent DDS Initials) ____ / ____ / ____ (Date) ______________________________

____ / ____ (Parent DDS Initials) ____ / ____ / ____ (Date) ______________________________

____ / ____ (Parent DDS Initials) ____ / ____ / ____ (Date) ______________________________

Authorization

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date ____ / ____ / ____

❑ Parent or Guardian ❑ Other: