Welcome

*Today's Date*_____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____
*Nickname*_____*Sex*_____
*Birthdate*_____*Age*_____
*School*_____*Grade*_____
*Street address*_____
*City*_____*St*___ *Zip*_____
*Phone*_____

Who is responsible for making appointments?
*Name*_____
*Home Phone*_____*Cell*_____
*Work Phone*_____ *Ext*_____

Responsible Party

*Name*_____
*Home Phone*_____*Cell*_____
*Work Phone*_____*Ext*_____
*Email*_____
*Employer*_____
*Occupation*_____
*SS#*_____

*Best time to call*_____
*Time*_____*Days*_____

Mother Stepmother Guardian

*Name*_____
*Home Phone*_____*Cell*_____
*Work Phone*_____*Ext*_____
*Email*_____
*Employer*_____
*Occupation*_____
*SS#*_____
Marital Status *Married Single*
Divorced Widowed Separated

Father Stepfather Guardian

*Name*_____
*Home Phone*_____*Cell*_____
*Work Phone*_____*Ext*_____
*Email*_____
*Employer*_____
*Occupation*_____
*SS#*_____
Marital Status *Married Single*
Divorced Widowed Separated

Primary Insurance

*Insured's Name*_____
*Relationship*_____
*Birthdate*_____*SS#*_____
*Employer*_____
*Occupation*_____
*Insurance Company*_____
Group # _____*Employee#*_____
*Ins. Co. Address*_____
*City*_____*St*____ *Zip*_____
*Deductible*_____ *Copay*_____

Additional Insurance

*Insured's Name*_____
*Relationship*_____
*Birthdate*_____*SS#*_____
*Employer*_____
*Occupation*_____
*Insurance Company*_____
Group # _____*Employee#*_____
*Ins. Co. Address*_____
*City*_____*St*____ *Zip*_____
*Deductible*_____ *Copay*_____

Financial Arrangements

For your convenience, we offer the following methods of payment: Cash, Check, Credit Cards and CareCredit

Dental & Health History

Your child's overall health as well as medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?_____
How often does your child floss?_____
Is your child's water fluoridated? Yes No
Take fluoride supplements? Yes No

Does your child

Suck thumb/finger Yes No
Suck/bite lip Yes No
Bite/Chew nails Yes No
Chew hard objects (pencils, etc.) Yes No
Grind teeth Yes No
Clench jaws Yes No

Previous dentist_____
Address_____
City_____St____Zip_____
Date of last dental visit_____
Has your child had difficulty with previous dental visits? Yes No
Child's physician_____
Address_____
City_____St____Zip_____
Phone #_____
Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____
_____
_____

Is your child currently taking medications? No Yes (Please list)

_____
_____

Has your child ever taken Fen-Phen/Redux? Yes No
Does your child have a history of allergies, sensitivities, adverse reactions to any drugs or medications (penicillin, Novocain, etc)? Yes No
If yes, describe_____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____
_____

Has your child ever had any of the following?

Asthma	*Yes*	*No*
Cancer	*Yes*	*No*
Hepatitis	*Yes*	*No*
HIV/AIDS	*Yes*	*No*
Hemophilia	*Yes*	*No*
Stomach, liver or kidney problems	*Yes*	*No*
Handicaps/Disabilities	*Yes*	*No*
Tuberculosis	*Yes*	*No*
Diabetes	*Yes*	*No*
Rheumatic Fever	*Yes*	*No*
Congenital Heart Defect	*Yes*	*No*
Heart Murmur	*Yes*	*No*
Convulsions/Epilepsy	*Yes*	*No*
Abnormal bleeding	*Yes*	*No*

A persistent cough or throat clearing not associated with a known illness, lasting more than 3 weeks? Yes No
Please explain any medical problems that your child has:_____

_____
_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform necessary dental services my child may need. I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____
Signature parent/guardian Date

_____
Dentist Review Date