

WELCOME

1

About Your Child

Today's Date: ___/___/___ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home Phone #: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

2

Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3

Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? _____ Age(s): _____

Mother's Name: _____
 STEP MOTHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____) (_____)
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
 STEP FATHER GUARDIAN

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) (_____) (_____)
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS CITY STATE ZIP

4

Account Information

Person ultimately responsible for account

Name: _____
RELATION TO CHILD

Billing Address: _____

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) (_____) (_____)
WORK PHONE # EXT. CELL PHONE #

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5

Child's Dental Information

Reason for today's visit: Exam Emergency ConsultationIs Child in pain? No Yes How Long? _____Please indicate any of the following problems:

- Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained teeth
 Red, swollen or bleeding gums. Teeth grinding Locking Jaw
 Sensitive tooth, teeth or gums. Ringing in Ears Bad breath
 Blisters/Sores in or around the mouth. Broken/Chipped tooth Loose tooth
 Other(s): _____

Does child require pre-medication? Yes No Don't know

Previous Dentist: _____ (____) _____

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? Yes No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6

Child's Medical History

Is Child taking any of the following medications? Pain killers (INCLUDING ASPIRIN) Ritalin Stimulants Blood Thinners Tranquilizers Insulin Muscle relaxers Others: _____Child's Physician: _____ (____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

Last Medical Exam: ____ / ____ / ____

ADDRESS CITY STATE ZIP

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Artificial Bones/Joints/Implants |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Liver/Kidney/Organ Problems |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Leukemia/Anemia | <input type="checkbox"/> HIV/AIDS/ARC |
| <input type="checkbox"/> Surgeries/Operations | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Tuberculosis TB |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hyper Active/ADD |
| <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Fainting/Seizures/Epilepsy |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Cerebral Palsy |

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

Is Child allergic to: Latex Penicillin/Amoxicillin Tetracycline Dental Anesthetics (Novocaine) Aspirin Food allergies Other(s): _____Please rate the child's general health from 1-10: _____ Does child wear contact lenses? Yes NoHas this child ever taken the drug Ritalin? No Yes/How long? _____ Child's Blood type: _____Does this child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking Heavy Snoring Mouth Breathing Lip Sucking/Biting

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.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

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 OtherUPDATE
OFFICE USE

Initials _____ Date ____ / ____ / ____

Comments _____

Initials _____ Date ____ / ____ / ____

Comments _____

Initials _____ Date ____ / ____ / ____

Comments _____