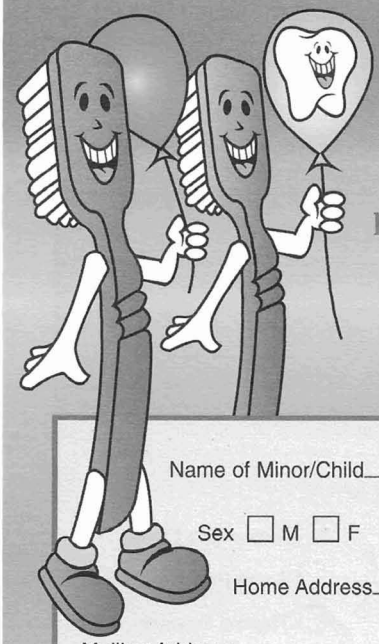
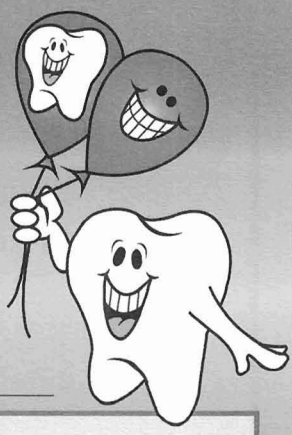


Welcome!



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 you in maintaining your child's dental health.

PATIENT INFORMATION

Date_____

Name of Minor/Child_____
Last Name First Name Initial

Sex ☐ M ☐ F Age_____ Birthdate_____ Nickname_____ Hobbies_____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Person financially responsible_____ Home Phone_____ Work Phone_____

Whom may we thank for referring you?_____

INSURANCE

Father's/Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ (if different from above) Work Phone_____ (if different from above)

Employer_____

Soc. Sec. #_____ Birthdate_____

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

Plan Name_____

Phone No._____

Address_____

Group #_____

Policy #_____

Mother's/Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ (if different from above) Work Phone_____ (if different from above)

Employer_____

Soc. Sec. #_____ Birthdate_____

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

Plan Name_____

Phone No._____

Address_____

Group #_____

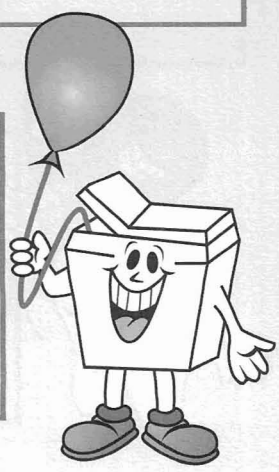
Policy #_____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. #_____

DENTAL HISTORY

Date of last visit to a dentist_____ For what service?_____

	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?	☐	☐



Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician_____ City/State_____ Phone_____

Date of last physical examination_____ Results_____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

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.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

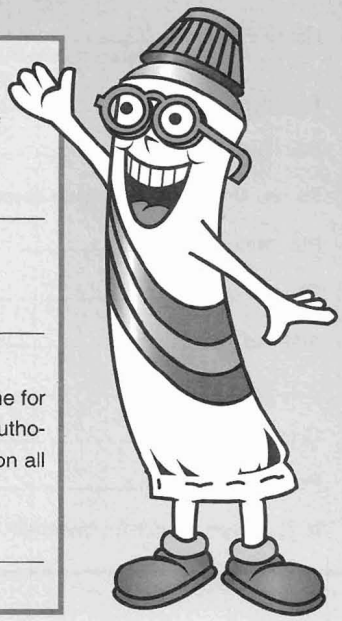
EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

AUTHORIZATIONS



The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____ _____

Signature of Parent/Guardian Date

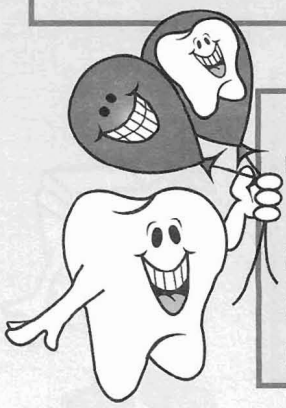
I certify that my minor/child is covered by insurance with_____

Name of Insurance Company(ies)

and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date



UPDATE

(To be completed at later visit)

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe_____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list_____

Date_____ Parent/Guardian Signature_____

Date_____ Dentist Signature_____

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