Welcome	***Thank you for selecting our dental healthcare team. We will strive to provide your child with the best possible dental care. To help us meet all of your child's dental needs, please fill out this form completely. If you have any questions, or need assistance, please ask us - we will be happy to help.***

Child Patient Information (Confidential)

*Date*_____

Child's Name _____ *Referred By* _____

*Residence Address*_____ *City* _____ *Zip* _____

Mailing Address (If different) _____ *E-Mail* _____

Phone _____ *Father's Cell* _____ *Mother's Cell* _____

Child's Soc. Sec.# _____ *Child's Birthdate* _____

Father's Name _____ *Soc. Sec #* _____ *Birthdate* _____

Father's Employer _____ *Father's Work Phone* _____

Father's Employer's Address _____ *Zip* _____

How Long Has He Worked for this Employer? _____

Mother's Name _____ *Soc. Sec. #* _____ *Birthdate* _____

Mother's Employer _____ *Mother's Work Phone* _____

Mother's Employer's Address _____ *Zip* _____

How Long Has She Worked for this Employer? _____

Other Than Parent, Person to Contact in Case of Emergency _____ *Phone* _____

Person Responsible for Account: ☐ *Father* ☐ *Mother* ☐ *Other*

Does Responsible Person Have a Checking Account? ☐ *Yes* ☐ *No* *Credit Card?* ☐*Yes* ☐ *No*

Insurance Information:

I have dental insurance ☐**Yes** ☐ **No. If you have insurance, let us copy your card. Without your card or the information on your card, we cannot file your claim. Please review the attached blue sheet, "How We Help With Your Dental Insurance".**

Appointment Information:

Please reserve appointments only at a time you know you will be available. If you find it necessary to change an appointment, please give us at least one *full* business day's notice. Our usual business days are Monday, Tuesday, Wednesday, and Friday. We reserve the right to charge for appointments cancelled, changed, or failed with less than one *full* business day's notice. The usual charge is $20 for each 10 minutes of reserved time.

I have read, understand and agree to the above *"Appointment Information".* Initials Please _____

_____

_____

_____

Child Medical History *(Please mark each item "Yes" or "No".)*

Medical Doctor's Name _____ *Date of Last Exam* _____

Reason for this Dental Appointment _____

	Yes	No
1. Is your child under medical treatment now? ……	□	□
2. To what medications is he/she allergic?		

_____

3. List Hospitalizations for Serious Illness or Surgeries _____

___ _____

	Yes	No
4. List Medications (prescription and non-prescription) taken on a regular basis _____		
5. Does your child have any unusual speech habits?	□	□
6. Does your child have any mouth habits (thumb-sucking, nail biting, mouth breathing)?.....	□	□

Does your child have or has he/she had any of the following? (Please mark each item "Yes" or "No".)

	Yes	No		Yes	No		Yes	No
Heart Disease/Trouble.....	□	□	Epilepsy/Convulsions.....	□	□	Hay Fever/Allergies.....	□	□
Heart Surgery.....	□	□	Leukemia.....	□	□	Tuberculosis.....	□	□
Blood Clotting Disorders.....	□	□	Diabetes.....	□	□	AIDS or HIV Infection.....	□	□
Anemia.....	□	□	Kidney Disease.....	□	□	Hepatitis.....	□	□
Fainting or Seizures.....	□	□	Respiratory Problems.....	□	□	Other.....	□	□
			Asthma.....	□	□			

Child Dental History *(Please mark each item "Yes" or "No".)*

	Yes	No
1. Do your child's gums bleed while brushing or flossing?....	□	□
2. Does your child have painful teeth or gums?	□	□
3. Are his/her teeth sensitive to sweet liquids/foods?	□	□
4. Does he/she have any sores or lumps in or near the mouth?	□	□
5. Has he/she had any head, neck, tooth or jaw injuries?.....	□	□
6. Has your child had any unhappy dental experiences?.....	□	□

Why did you leave your last dental office? _____

_____

_____

Date of last dental visit: _____

	Yes	No
7. Has your child ever had any orthodontic treatment or appliances (retainers)?	□	□
8. Do you want him/her to have instructions on the correct method of brushing and flossing?	□	□
9. Are you happy with the appearance of your child's teeth?	□	□
10. Brushing - how often? _____	□	□
11. Flossing - how often?_____		
12. What other dental questions would you like us to answer? _____		

_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information, and to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company or dental group benefits to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered in excess of my insurance payments. I also agree to be responsible for payment of any charges related to the collection of this account should it become past-due by 90 days or more. I will report any changes in my child's health or medicines at the next appointment.

Parent/Guardian Signature: _____ Date: _____ Dr. Initials _____