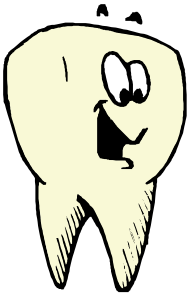

Welcome

We look forward to working with you in maintaining your child's dental health. Please take a few minutes to fill out this form.

Patient Information

Date_____ **SS/HIC/Patient ID#**_____ **Birthdate**_____

Name of Minor/Child_____ **Sex** ☐ **M** ☐ **F Age**_____

Last First Middle initial

Nickname_____ **Cell Phone** _____

Home Address_____

Street City State Zip

Mailing Address_____

Street City State Zip

School Name_____ **School Phone**_____

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 ph._____ **Work ph.** _____

Email_____

Employer_____

SSN_____ **Birthdate**_____

Do you have dental ins. coverage for minor/child?___

Plan Name_____ **Phone**_____

Address_____

Group# _____ **Policy #**_____

Mother's/Guardian's Name_____

Address (if different from patient's) _____

_____

Home ph._____ **Work ph.**_____

Email_____

Employer_____

SSN_____**Birthdate**_____

Do you have dental ins. coverage for minor/child?___

Plan Name_____ **Phone**_____

Address_____

Group#_____ **Policy#**_____

Is your child eligible for treatment under Medical Assistance? _____ Child's Medical Assistance ID # _____

Dental History

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

Has child complained about dental problems? **Y N**

Does child brush teeth daily? **Y N**

Does child use floss every day? **Y N**

Is fluoride taken in any form? **Y N**

Any injuries to mouth, teeth, head? **Y N**

Any unhappy dental experiences? **Y N**

Any mouth habits—thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? **Y N**

(continue to next page)

Medical History

Child's Physician_____ **City/State**_____**Phone**_____

Date of last physical examination_____ **Results**_____

Is minor/child under care of physician now? **Y N** **Medications**_____

Receiving any medication or drugs? **Y N** _____

Ever been hospitalized? **Y N** **Allergies**_____

Ever had surgery? **Y N** _____

Is there excessive bleeding when cut? **Y N**

Has minor/child had any history of or difficulty with any of the following? If yes, please circle.

A.I.D.S./H.I.V	Cerebral Palsy	Epilepsy	Kidney Disease
Rheumatic Fever	Anemia	Chicken Pox	Fainting
Liver Disease	Sinus Problems	Asthma	Bladder Problems
Cancer	Convulsions	Diabetes	Drug/Alcohol Abuse
Hearing problems	Heart problems	Hepatitis	Measles
Mononucleosis	Mumps	Thyroid Disease	Tuberculosis

Other

Emergency Contact

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

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Authorizations

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

I am the parent, guardian or personal representative of _____

Please print name of minor/child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I certify that my dependent(s) 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 authorize the use of my signature on all insurance submissions.**

The above-named doctor may use my child's health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

_____ _____

Signature of Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print name of Parent, Guardian or Personal Representative **Relationship to Patient**