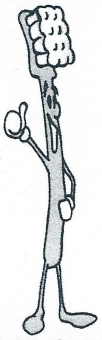
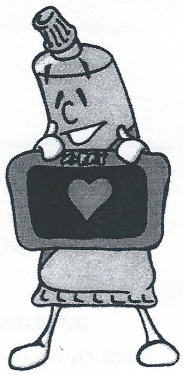


WELCOME!



Thank you for your visit today! We are pleased to welcome you and your child to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you to maintain your child's dental health!

PATIENT INFORMATION

Date _____ Home phone _____

Child's Name _____ Nickname _____

Sex ☐ Male ☐ Female Age _____ Birthday _____

Home address _____

Mailing address _____

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 _____ Work Phone _____

Employer _____

Social Security # _____ Birthdate _____

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

Plan Name _____

Address _____

Phone Number _____

Group # _____

Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home phone _____ Work Phone _____

Employer _____

Social Security # _____ Birthdate _____

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

Plan Name _____

Address _____

Phone Number _____

Group # _____

Policy # _____

Is your child eligible for Medical Assistance treatment? ☐ Yes ☐ No Child's Medical Assistance ID # _____

DENTAL HISTORY

Date of last dental visit _____ For what service? _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, or head?	☐	☐
Does child floss teeth daily?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? _____

_____

MEDICAL HISTORY

Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

_____

	Yes	No
Is child under the care of a physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

Allergies _____

_____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

☐ AIDS/HIV	☐ 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	☐ Kidney Disease
☐ Cancer	☐ Drug/Alcohol abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY INFORMATION

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur.

I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

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 on behalf of my dependents.

Signature of parent or guardian _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.