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 dental health.

Patient Information

Date _____ Birthdate _____

Name of minor child _____ Age _____

Last Name First Name Middle Initial

Sex ☐ M ☐ F Nick Name _____ Hobbies _____

Address _____ Cell Phone (___)_____

City _____ State _____ Zip_____

School _____

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 (___)_____
(if different from above)

e-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

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

Plan Name _____ Phone # _____

Group # _____ Policy # _____

Mother's/Guardian's Name_____

Address (if different from patient's) _____

_____

Home Phone (___)_____ Work Phone (___)_____
(if different from above)

e-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

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

Plan Name _____ Phone # _____

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		Yes	No
Has child complained about dental problems	☐	☐	Is fluoride taken in any form	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Any mouth habits – thumb sucking, 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 a physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

MEDICATIONS _____

_____

ALERGIES _____

_____

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	☐ Fainting	☐ Measles	☐ Tonsillitis
☐ Anemia	☐ Chicken Pox	☐ Hearing Problems	☐ Mononucleosis	☐ Thyroid Disease
☐ Asthma	☐ Convulsions	☐ Heart Problems	☐ Mumps	☐ Tuberculosis
☐ Autism	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever	☐ Vision Problems
☐ Bladder Problems	☐ Drug / Alcohol abuse	☐ Kidney Disease	☐ Scarlet Fever	☐ Other _____
☐ Cancer	☐ Epilepsy	☐ Liver Disease	☐ Sinus Problems	_____

Emergency Contact

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

Name _____ Relationship _____ Phone (____)_____

Authorization

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.

Minor / Child Consent

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 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 my behalf.

Signature _____ Date _____