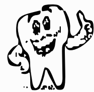
WELCOME!

ABOUT YOUR CHILD:

TODAY'S DATE ___/___/___

Child's Name:____ ( ) Boy ( ) Girl
Last First M.I.
Child's Birthdate:___/___/___ Age:______ Phone#(____)______________
Child's Address:____
Street City State Zip
Referred By:________________



INSURANCE INFORMATION:

Primary Insurance:____________________
Phone#:____________________
Insured's ID#:____________________
Group #:____________________
Insured's Name:____________________
Relation:____________________
Insured's Date of Birth:____________________

Secondary Insurance:____________________
Phone#:____________________
Insured's ID#:____________________
Group#:____________________
Insured's Name:____________________
Relation:____________________
Insured's Date of Birth:____________________

CHILD'S FAMILY INFORMATION:

Who is accompanying this child today?____________________ ____________________
Full Name Relation to child

Do you have Legal Custody of this Child? ( ) Yes ( ) No

Mother's Name:____________________
( ) Step Mother ( ) Guardian
Home Address:____________________
( ) CHECK IF SAME AS CHILD'S
Home/Cell Phone#:____________________
Mother's Social Security #:____________________
Mother's Date Of Birth:____________________
Mother's Employer:____________________

Father's Name:____________________
( ) Step Father ( ) Guardian
Home Address:____________________
( ) CHECK IF SAME AS CHILD'S
Home/Cell Phone#____________________
Father's Social Security#:____________________
Father's Date Of Birth:____________________
Father's Employer:____________________

ACCOUNT INFORMATION:

Person ultimately responsible for account

Name:____________________
Billing Address:____________________
____

Relation To Child:____________________
Social Secuity #:____________________
Date Of Birth:____________________

________ I hereby authorize assignment of my insurance rights and bebnefits to the provider for services rendered. I fully
initials understand I am soley responsible for any balance not paid by my insurance company (If offered at this office).

CHILD'S DENTAL INFORMATION:

Reason for today's visit: ( ) Exam ( ) Emerency ( ) Consultation Is child in pain? ( ) No ( ) Yes How Long?________

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw	____	Lost/Broken filling(s)	____	Stained teeth	____
Red, swollen or bleeding gums	____	Teeth grinding	____	Locking Jaw	____
Sensitive tooth, teeth or gums	____	Ringing in Ears	____	Bad breath	____
Blisters/Sores in or around the mouth	____	Broken/Chipped tooth	____	Loose tooth	____

Other:______________________________

Does child require pre-medications? ( ) Yes ( ) No ( ) Don't know

Previous Dentist:______________________ Phone #:______________________

Last Dental Exam: ___/___/___ Last Dental X-ray:___/___/___

Times a day child brushes?_____ Times a week child flosses?_______

Is the child's water fluoridated? ( ) Yest ( ) No

How would you rate the child's smile? **Worst** 1 2 3 4 5 6 7 8 9 10 **Best**

CHILD'S MEDICAL HISTORY

Is Child taking any of the following medications? ( ) Pain killers (Including Aspirin) ( ) Ritalin ( ) Stimulants ( ) Blood Thinners ( ) Tranquilizers ( ) Insulin ( ) Muscle relaxers ( ) Others:________________

Child's Physician:________________________ Phone#:(____) ________________

Address:______________________________ Last Medical Exam:____/____/____

Does Child Have or ever had any of the following diseases, medical conditions or procdures?

Yes___	No ___	Heart Murmur	Yes___	No ___	Tonsilities	Yes___	No ___	High/Low Blood Pressure
Yes___	No ___	Rheumatic fever	Yes___	No ___	Respiratory Problems	Yes___	No ___	Hepatitis
Yes___	No ___	Artificial Heart Valves	Yes___	No ___	Asthma/Difficulty Breathing	Yes___	No ___	Artificial Bones/Joints/Implants
Yes___	No ___	Congenital Heart defect	Yes___	No ___	Blood Transfusion(s)	Yes___	No ___	Liver/Kidney/Organ Problems
Yes___	No ___	Scarlet Fever	Yes___	No ___	Leukemia/Anemia	Yes___	No ___	HIV+/AIDS/ARC
Yes___	No ___	Surgeries/Operations	Yes___	No ___	Diabetes/Hypoglycemia	Yes___	No ___	Tuberculosis TB
Yes___	No ___	Cancer/Tumors	Yes___	No ___	Hemophilia	Yes___	No ___	Psychiatric Problems
Yes___	No ___	Chemotherapy	Yes___	No ___	Abnormal Bleeding	Yes___	No ___	Hyper Active/ADD
Yes___	No ___	Jaw Problems TMJ/TMD	Yes___	No ___	Cleft Lip/Palate	Yes___	No ___	Fainting/Seizures/Epilepsy
Yes___	No ___	Hearing Problems	Yes___	No ___	Birth Defects	Yes___	No ___	Cerebral Palsy

Please list any other medical condition(s) child has or ever had:______________________________

Is Child allergic to: ( ) Latex ( ) Penicillin/Amoxicillin ( ) Tetracycline ( ) Dental Anesthetics (Novocaine) ( ) Aspirin ( ) Food Allergies ( ) Other(s):______________________________

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ( ) Yes ( ) No

Has this child ever taken the drug Ritalin? ( ) No ( ) Yes/How long?______ Child's Blood type:______

Does this child do any of the following? ( ) Thumb/Finger Sucking ( ) Tongue Thrusting/Sucking ( ) Heavy Snoring ( ) Mouth Breathing ( ) Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If you account is not paid within 90 days from the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to relase any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:______________________________ Date:____/____/____

( ) Parent or Guardian ( ) Other