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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.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ 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? _____ Phone # () _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home # () _____ Work # () _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

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

Plan Name _____ Phone () _____

Address _____

Group# _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home # () _____ Work # () _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

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

Plan Name _____ Phone () _____

Address _____

Group # _____ Policy # _____

DENTAL HISTORY

| | |
|--|--|
| Date of last visit to a dentist _____ | For what service? _____ |
| Has child complained about dental problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is fluoride taken in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does child brush teeth daily? <input type="checkbox"/> Yes <input type="checkbox"/> No | Any injuries to mouth, teeth, head? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does child use floss every day? <input type="checkbox"/> Yes <input type="checkbox"/> No | Any unhappy dental experiences? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any learning problems? <input type="checkbox"/> Yes <input type="checkbox"/> No | Any school problems? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

MEDICAL HISTORY

Pediatrician _____ Address & Phone# _____

- | | | | |
|---|--------------------------|--------------------------|-------------------|
| | Yes | No | |
| Is Minor/Child under care of physician now? | <input type="checkbox"/> | <input type="checkbox"/> | Medications _____ |
| Receiving any medication or drugs? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | Allergies _____ |
| Is there excessive bleeding when cut? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓)

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

ATTENTION BEHAVIOR

- | | | | | |
|--|------------------------------|------------------------------|--|--------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> ADD | <input type="checkbox"/> PDD | <input type="checkbox"/> HYPERACTIVITY | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> Autism Spectrum _____ | | | | |
| <input type="checkbox"/> Sensory Issues _____ | | | | |
| <input type="checkbox"/> Social Issues _____ | | | | |

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.

Insurance Assignment and Release

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 minor/child's health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I have reviewed the offices "Notice of Privacy Practice" policy.

| | |
|--|---|
| _____ <small>Signature of Parent, Guardian or Personal Representative</small> | _____ <small>Date</small> |
| _____ <small>Please Print Name of Parent, Guardian or Personal Representative</small> | _____ <small>Relationship to Patient</small> |

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____