

# Welcome

Patient ID # \_\_\_\_\_ Today's Date \_\_\_\_\_

*to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.*

## Your Child

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

## Who is responsible for making appointments?

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Best time to call \_\_\_\_\_  
Time \_\_\_\_\_ Days \_\_\_\_\_

### Mother

Stepmother  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

### Father

Stepfather  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

**Marital Status**  Single  Married  Divorced  
 Widowed  Separated

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 Widowed  Separated

## Primary Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.  Cash  Personal Check  
 Credit Card  Visa  MC  I wish to discuss the office's payment policy.

**Dental & Health History**

**CONFIDENTIAL**

Patient ID # \_\_\_\_\_

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? \_\_\_\_\_ How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated?.....  Yes  No Does your child take fluoride supplements?.....  Yes  No

Does your child:

Suck thumb/finger .....  Yes  No Chew hard objects (pencils, etc.) .....  Yes  No

Suck/Bite lip .....  Yes  No Grind teeth .....  Yes  No

Bite/Chew nails?.....  Yes  No Clench jaws .....  Yes  No

Previous dentist \_\_\_\_\_ Address \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Has your child had difficulty with previous dental visits?  Yes  No

Child's physician \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses? \_\_\_\_\_ When? \_\_\_\_\_

Is your child currently taking medications?  Yes  No (if yes, please list) \_\_\_\_\_

Has your child ever taken Fen-Phen/Redux?  Yes  No \_\_\_\_\_

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)?  Yes  No (if yes, please describe) \_\_\_\_\_

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? \_\_\_\_\_

Has your child ever had any of the following:

Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach, liver or kidney problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks), ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	Convulsions/Epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any medical problems that your child has: \_\_\_\_\_

**Authorization & Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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 or my dependents.

Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_  
Dentist Review: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_