



WELCOME



1 About Your Child

Today's Date: ___/___/___ File #: _____

Child's Name: _____
LAST * FIRST M.I.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ___/___/___ Age: _____

School: _____ Grade: _____

Child's Home Phone #: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

3 Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? _____ Age(s): _____

MOTHER'S NAME STEP MOTHER GUARDIAN _____
EMAIL ADDRESS

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP
 (_____) _____
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # _____ DATE OF BIRTH _____ MOTHER'S DRIVERS LIC. # _____

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS _____ CITY STATE ZIP

FATHER'S NAME STEP FATHER GUARDIAN _____
EMAIL ADDRESS

(CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP
 (_____) _____
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # _____ DATE OF BIRTH _____ FATHER'S DRIVERS LIC. # _____

Employer: _____ How Long? _____

EMPLOYER'S ADDRESS _____ CITY STATE ZIP

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? Yes No

Secondary Dental Insurance

Co. Name: _____

Address: _____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

4 Account Information

Person ultimately responsible for account

Name: _____
RELATION TO CHILD

Billing Address: _____
CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) _____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials _____

Please Continue On Back



5

Reason for today's visit: Exam Emergency 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(s): _____

Does child require pre-medication? Yes No Don't know

Previous Dentist: _____ (____) _____

Last Dental exam: ___ / ___ / ___ Last Dental X-rays: ___ / ___ / ___

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

Is the child's water fluoridated? Yes No

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

6

Is Child taking any of the following medications? Pain killers (INCLUDING ASPIRIN) Ritalin Stimulants
 Blood Thinners Tranquilizers Insulin Muscle relaxers Others: _____

Child's Physician: _____ (____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

ADDRESS CITY STATE ZIP Last Medical Exam: ___ / ___ / ___

Does Child have or ever had any of the following diseases, medical conditions or procedures?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Artificial Bones/Joints/Implants |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Liver/Kidney/Organ Problems |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Leukemia/Anemia | <input type="checkbox"/> HIV+/AIDS/ARC |
| <input type="checkbox"/> Surgeries/Operations | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Tuberculosis TB |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Hyper Active/ADD |
| <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Fainting/Seizures/Epilepsy |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> 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 account is not paid within 90 days of 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 release 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.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials _____

Signature _____ Date ___ / ___ / ___

Parent or Guardian Other:

UPDATE (OFFICE USE)

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments

Initials _____ / _____ / _____
Date

Comments