Patient Information

Child's name: ____Nickname:________________________________ Sex: (M) (F)

Purpose of visit: ______________________________________Concerns:________________________________Birthdate:__________

Name and age of brothers/sisters: ____Is your child adopted? Y N

Child's Interests: ____Name of Pet(s):________________________________

Does your child have any special needs? ____ Any phobias? __________________

Allergies? ____

Child's learning: slow average accelerated Child's school: ____

Who may we thank for referring you to us? ____

Health History

Child's Pediatrician: ______________________________ Phone number : (______)_____________Last Physical: _________________

Is your child under a physician's care now? Y N If yes, reason: __________________________________ Immunization up to date? Y N

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N If yes, please list in the back

Is your child allergic to any medication? Y N If yes, please list: ____

Any history of hospitalization or surgery: (if yes, when)____

Has your child had any history or ever been diagnosed with any of the following?

- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Diabetes
- ☐ Fainting
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Measles
- ☐ Mumps
- ☐ Cancer, type ___________________________
- ☐ Allergy/Hay fever
- ☐ Arthritis/ Rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joint/limb
- ☐ Epilepsy/seizure
- ☐ Birth defects
- ☐ Bleeding Disorder
- ☐ Brain injury
- ☐ Brain surgery
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Cleft lip/palate
- ☐ Eye problems
- ☐ Growth problem
- ☐ Heart murmur
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Mental retardation
- ☐ Other ____
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Scoliosis
- ☐ Shunt
- ☐ Tetanus
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Attention Deficit Disorder
- ☐ Behavior/Learning Disabilities
- ☐ Bone/Joint/orthopedic problem
- ☐ Digestive disturbances
- ☐ Hearing loss/aids/implants
- ☐ Heart problem/surgery
- ☐ High/low blood pressure
- ☐ Hormonal disturbances
- ☐ Malignant hyperthermia
- ☐ Whooping cough

Dental History

Is this your child's first dental visit? Y N If no, previous dentist: ________________________ Phone number: (____)________________

Date of last visit: ___________ How was his/her experience? _____________________________________ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: ____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: ____

Has your child done any of the following (past or present)? Please check:

☐ thumb/finger-sucking ☐ pacifier ☐ nail biting ☐ lip sucking ☐ mouth-breathing ☐ snoring ☐ teeth grinding ☐ nursing ☐ bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? _________ With adult supervision? Y N How often does your child floss? __________

How may we help to make this visit a positive experience for your child? ____

For families with reverse osmosis filtration or in an unfluoridated area, are you interested in a fluoride supplement? Y N

Patient Information

General Information

Father (full name) ___________________________SSN:________________Birthdate:____________Driver's License #:___________

Mother (full name) ___________________________SSN:________________Birthdate:____________Driver's License #:___________

Parent(s) are: Married____ Divorced____ Single____ Widowed____ Partners____ Child lives with: both parents mother father other Home

Address: ____Home Phone: (_____)______________
Street City Zip

Father's Employer: ____Cellular Phone: (_____)_____________

Business Address:____Work Phone: (_____)________________

Mother's Employer: ____Cellular Phone: (_____)_____________

Business Address:____Work Phone: (_____)________________

E-mail Address:___________________________________ Person financially responsible for child's dental care:__________________

Emergency Contact:____ Relationship: _________________Phone: (_____)____________

Address:____

How would you like us to contact you? Home Work Cell E-mail

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:____Relationship:______________________Date:____________

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company:____Group Number:____________________________

Address of Father's Insurance Company:____

Mother's Insurance Company:____Group Number____________________________

Address of Mother's Insurance Company:____

Financial Agreement

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $25 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion the day of dental treatment.

For patients without insurances: payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $25 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

SIGNATURE:____Relationship:________________________ Date:_____________