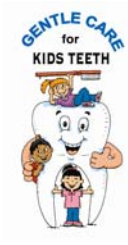
Welcome



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. If you have any questions we will be glad to help. We look forward to working with you in maintaining your child's dental health.

Patient information

Date _____ SS/Patient ID# _____ Birthdate _____

Name of minor _____ Sex: M or F Age _____
last name first name

Nick Name _____ Hobbies _____

Home address _____
Street City State Zip

School Name _____ School phone _____

Person financially responsible _____ Home phone _____ Cell phone _____

How did you hear about us? _____ Work phone _____

Insurance

Father's/Guardian's Name_____

Address (if different from patient's)_____

Home phone_____ Work phone_____ E-mail_____

Employer_____ Soc Sec #_____ DOB_____

Do you have dental coverage for the minor/child ____ yes _____ no

Plan Name_____ Phone( )_____

Address_____

ID#_____ Group #_____ Policy#_____

Mother's/Guardian's Name_____

Address (if different from patient's)_____

Home phone_____ Work phone_____ E-mail_____

Employer_____ Soc Sec #_____ DOB_____

Do you have dental coverage for the minor/child? ____ yes _____ no

Plan Name_____ Phone( )_____

Address_____

ID#_____ Group #_____ Policy#_____

Is your child eligible for treatment under Medical Assistance? _____yes _____no
Child's Medical Assistance ID#_____

Dental History

Date of last visit to a dentist_____ For what service_____

Has child complained about dental problems? Y/N Is fluoride taken in any form? Y/N

Does child brush teeth daily? Y/N Any injuries to mouth, teeth, head? Y/N

Does child use floss every day? Y/N Any unhappy dental experiences? Y/N

Any mouth habits–thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?

Medical History

Minor/Child's Physician_____ City/State_____ Phone(___)_____

Date of last physical examination_____ Results_____

Is Minor/Child under care of physician now? Y/N Dr. _____

Receiving any medication or drugs? Medications_____

Ever been hospitalized?_____

Ever had surgery?_____ Allergies_____

Is there excessive bleeding when cut? _____

Has minor/child had any history of or difficulty with any of the following? If yes, please circle.

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

Emergency Contact

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone(____)_____

Name_____ Relationship_____ Phone(____)_____

Authorizations

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, including buy not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

And assigned 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 by minor/child's health care information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan I completed or one year from the date signed.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of parent, Guardian or Personal Representative Relationship to Patient