

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 questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Date: _____

Child's name _____ Soc. Sec. # _____
Address _____
City _____ State _____ Zip _____
Home Phone Number _____ Cell Phone _____
Sex M ___ F ___ Age _____ Birthdate _____ School _____
Grade _____ Hobbies/Sports _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Home Phone _____
Business Phone _____ Cell Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Relation to Child _____ Birth date _____ Soc. Sec. # _____
Address (if different from child) _____
City _____ State _____ Zip _____ Home Phone _____
Cell Phone _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Phone _____
Contract # _____ Group# _____ Subscriber# _____
Name of other dependents under this plan: _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? _____
Subscriber Name _____ Relation to Child _____ Birthdate _____
Address (if different from child) _____ Soc. Sec. # _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Subscriber Employed by _____ Business Phone _____
Insurance Company _____ Phone _____
Contract # _____ Group# _____ Subscriber# _____
Name of other dependents under this plan: _____

DENTAL HISTORY

What would you like us to do for your child today? _____

Former dentist: _____ Address: _____
Phone: _____
Date of last dental care _____ Date of last xrays: _____
How often does your child brush? _____ Floss: _____

Does your child experience pain or discomfort in the jaw joint? Yes ___ No ___
 Has your child ever experienced a mouth or chin injury? Yes ___ No ___
 Does your child have speech problems? Yes ___ No ___
 Has your child ever experience an adverse reaction during or in conjunction with a medical or dental procedure?
 Yes ___ No ___
 Child's habits affecting the mouth or teeth: Thumb sucking ___ Nail biting ___
 Other _____
 Other information about your child's dental health or previous treatment _____

MEDICAL HISTORY

Child's Physician _____ Phone _____
 Date of last visit _____

Has your child had any serious illnesses or operations: Yes ___ No ___
 If yes, please describe _____

Is your child currently under physician care? Yes ___ No ___ If yes, please describe _____

Has your child ever had a blood transfusion? Yes ___ No ___ If yes, approximate dates _____

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

Check yes or no whether your child has had any of the following:

- | | | |
|-----------------------------------|---------------------------------------------|----------------------------------------------------------------|
| AIDS/HIV positive.....yes no | Epilepsy.....yes no | Liver disease.....yes no |
| Anemia.....yes no | Fainting.....yes no | Material allergies (latex,
wool, metal, chemicals)...yes no |
| Asthma.....yes no | Food Allergies.....yes no | Respiratory disease.....yes no |
| Atopic (allergy prone).....yes no | Headaches.....yes no | Rheumatic/Scarlet fever.....yes no |
| Blood disease.....yes no | Hearing Impairment.....yes no | Shortness of breath.....yes no |
| Cancer.....yes no | Heart problems.....yes no | Sinus problems.....yes no |
| Chicken Pox.....yes no | Mitral Valve Prolapse.....yes no | Skin rash.....yes no |
| Convulsions/Epilepsy.....yes no | Heart Murmur.....yes no | Spina Bifida.....yes no |
| Cough, persistent.....yes no | Hemophilia/
Abnormal bleeding.....yes no | Thyroid disease/malfunction..yes no |
| Cough up blood.....yes no | Immunizations current.....yes no | Tonsillitis.....yes no |
| Diabetes.....yes no | Kidney disease or
malfunction.....yes no | Tuberculosis.....yes no |

Other.....yes no Describe _____

List medications your child is taking, if any:

List drug allergies, if any:

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in by child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature _____ Date _____

Dentist signature _____ Date _____