



# 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 you in maintaining your child's dental health.

Date \_\_\_\_\_

**PATIENT INFORMATION**

Name of Minor/Child \_\_\_\_\_  
Last Name First Name Initial

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Nickname \_\_\_\_\_ Hobbies \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

Person financially responsible \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**INSURANCE**

Father's/Guardian's Name _____ Address (if different from patient's) _____ Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small> Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone No. _____ Address _____ Group # _____ Policy # _____ Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's Medical Assistance I.D. # _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small> Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone No. _____ Address _____ Group # _____ Policy # _____
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**DENTAL HISTORY**

Date of last visit to a dentist \_\_\_\_\_ For what service? \_\_\_\_\_

Has child complained about dental problems? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO Does child brush teeth daily? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO Does child use floss every day? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO	Is fluoride taken in any form? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO Any injuries to mouth, teeth, head? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO Any unhappy dental experiences? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO
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Please Complete Both Sides

**MEDICAL HISTORY**

Minor/Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

	YES	NO	
Is Minor/Child under care of physician now? .....	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
Receiving any medication or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

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

**EMERGENCY CONTACT**

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**AUTHORIZATION**

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

I certify that my minor/child is covered by insurance with:

\_\_\_\_\_

Name of Insurance Company(ies)

and assign 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_



**UPDATE**

**TO BE COMPLETED AT LATER VISIT**

Has there been any change in patient's health since last dental appointment?  Yes  No

If yes, please describe \_\_\_\_\_

Is patient taking any new medications?  Yes  No If yes, please list \_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

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