

thank you for selecting us.

Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ Social Security # _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City, State, Zip _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____

City, State, Zip _____ Phone _____

Social Security # _____ DL# _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information

Mother

Stepmother

Guardian

Name _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father

Stepfather

Guardian

Name _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

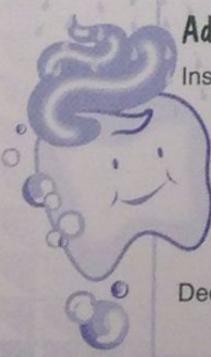
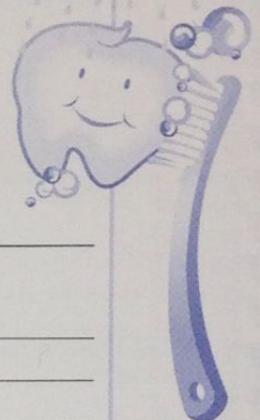
Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please



Dental/Medical Health History (Confidential)

Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

Date of Last Dental Visit _____

How often does your child floss? _____

For what service _____

Child attitude to dentistry _____

Previous Dentist _____

Is your child's water fluoridated? Yes No
 Does your child take fluoride supplements? Yes No

Address _____
 Has child complained about dental problems _____ Yes No

Does your child:
 Suck Thumb/Finger Yes No

Any injuries to mouth - teeth - head _____ Yes No

Suck/Bite Lip Yes No

Any unusual speech habits _____ Yes No

Bite/Chew Nails Yes No

Any lost teeth _____ Yes No

Chew Hard Objects (pencils, etc.) Yes No

Have missing teeth been replaced _____ Yes No

Grind Teeth Yes No

Orthodontic appliances worn now or ever been _____ Yes No

Clench Jaws Yes No

Do you assist child with tooth brushing _____ Yes No

Has your child had difficulty with previous dental visits? Yes No

How often _____
 Is dental floss used _____ Yes No

Do you desire complete dental service for the child _____ Yes No

How often _____
 Are disclosing tablets used _____ Yes No

Has your child ever had any of the following:

- | | | |
|--|---|--|
| Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Malignancies <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mastoid <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral Palsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach, Liver or Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic Sinus <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Veneral Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Other <input type="checkbox"/> Yes <input type="checkbox"/> No |

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Is your child currently taking any medications? Yes No (if yes, please list _____)

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No
 (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option your prefer. Payment in full at each appointment.

- Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Guardian, if minor _____ Date _____

Dentist's Review: _____

Signature of Dentist _____ Date _____