

W.E.L.C.O.M.E.

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.



PATIENT INFORMATION

DATE _____ SS / HIC / PATIENT ID # _____ BIRTH DATE _____

NAME OF MINOR / CHILD _____ SEX M F AGE _____

NICKNAME _____ HOBBIES _____ CELL PHONE () _____

HOME ADDRESS _____
STREET _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____
STREET _____ CITY _____ STATE _____ ZIP _____

SCHOOL NAME _____ SCHOOL PHONE () _____

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 PH () _____ WORK PH () _____
(if different from above) (if different from above)

EMAIL _____

EMPLOYER _____

SS # _____ BIRTH DATE _____

Do you have dental insurance coverage for minor/child? YES NO

PLAN NAME _____ PHONE () _____

ADDRESS _____

GROUP # _____ POLICY # _____

IS your child eligible for treatment under medical assistance? YES NO CHILD'S MEDICAL ASSISTANCE ID # _____

MOTHER'S / GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

HOME PH () _____ WORK PH () _____
(if different from above) (if different from above)

EMAIL _____

EMPLOYER _____

SS # _____ BIRTH DATE _____

Do you have dental insurance coverage for minor/child? YES NO

PLAN NAME _____ PHONE () _____

ADDRESS _____

GROUP # _____ POLICY # _____

DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST _____

Has child complained about dental problems? YES NO

Does child brush teeth daily? YES NO

Does child use floss everyday? YES NO

Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? _____

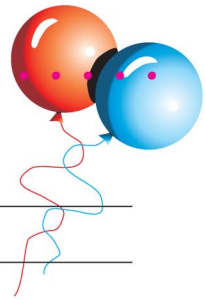
FOR WHAT SERVICE? _____

IS fluoride taken in any form? YES NO

Any injuries to mouth, teeth, head? YES NO

Any unhappy dental experiences? YES NO





MEDICAL HISTORY

MINOR / CHILD'S PHYSICIAN CITY / STATE PHONE ()

DATE OF LAST PHYSICAL EXAMINATION RESULTS

IS minor/child under care of physician now? Receiving any medication or drugs? Ever been hospitalized? Ever had surgery? IS there excessive bleeding when cut? MEDICATIONS ALLERGIES

HAS minor/child had any history of or difficulty with any of the following? If yes, please check (✓). AIDS / HIV, Anemia, Asthma, Bladder Problems, Cancer, Cerebral Palsy, Chicken Pox, Convulsions, Diabetes, Drug/Alcohol Abuse, Epilepsy, Fainting, Hearing Problems, Heart Problems, Hepatitis, Kidney Disease, Liver Disease, Measles, Mononucleosis, Mumps, Rheumatic Fever, Sinus Problems, Thyroid Disease, Tuberculosis, Other

EMERGENCY 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.

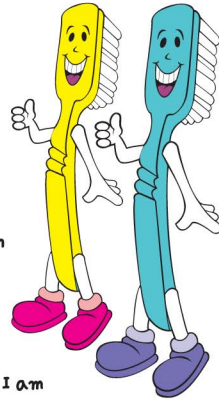
MINOR / CHILD CONSENT

I am the parent, guardian, or personal representative of 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 but 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 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 authorize the use of my signature on all insurance submissions. The above-named doctor may use my minor/child's health care information and may disclose such 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 is completed or one year from the date signed below.



Signature of Parent, Guardian or Personal Representative Date

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

UPDATE (to be filled in at future appointments)

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

