

Today's Date: _____

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birth date _____ Age _____
SS #/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State _____ Zip/P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State _____ Zip/P.C. _____
Email _____
SS #/SIN _____
DL # _____
Home phone _____
Cell phone _____

Mother Stepmother Guardian

Name _____
Home phone _____ Cell Phone _____
Email _____
Employer _____
Occupation _____
SS #/SIN _____
DL # _____
Marital Status: Single Married Divorced
 Widowed Separated

Father Stepfather Guardian

Name _____
Home phone _____ Cell Phone _____
Email _____
Employer _____
Occupation _____
SS #/SIN _____
DL # _____
Marital Status: Single Married Divorced
 Widowed Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS #/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City _____ State _____ Zip/P.C. _____
Deductible _____ Copay _____
Max. annual benefit _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS #/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City _____ State _____ Zip/P.C. _____
Deductible _____ Copay _____
Max. annual benefit _____

Payment philosophy available upon request.

OVER PLEASE

Medical Information (CONFIDENTIAL)

Child's Physician (M.D.) _____ Phone: _____

Address _____

City _____ State _____ Zip/P.C. _____

What medications is your child currently taking? _____

Please list any allergies? _____

Has your child had any of the following?

Asthma	Yes ___ No ___
Cancer	Yes ___ No ___
Hepatitis	Yes ___ No ___
HIV/AIDS	Yes ___ No ___
Hemophilia	Yes ___ No ___
Stomach, liver or kidney problems	Yes ___ No ___
A persistent cough or throat clearing not associated with a known illness	Yes ___ No ___
Handicaps/Disabilities	Yes ___ No ___
Tuberculosis	Yes ___ No ___
Diabetes	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___
Congenital Heart Defect	Yes ___ No ___
Heart Murmur	Yes ___ No ___
Convulsions/Epilepsy	Yes ___ No ___
Abnormal Bleeding	Yes ___ No ___

Please list any other medical problems _____

Previous Hospitalizations/Surgeries/Serious Illnesses? _____ When? _____

Dental Information

Previous Dentist _____

Date of last visit? _____

Address _____

City _____ State _____ Zip/P.C. _____

How often does your child brush his/her teeth? _____ Floss? _____

Is your child's water fluoridated? Yes ___ No ___

Does your child take fluoride supplements? Yes ___ No ___

Does your child:

Suck his/her thumb or finger? Yes ___ No ___

Suck or Bite their lip? Yes ___ No ___

Bite or Chew their finger nails? Yes ___ No ___

Chew on hard objects? Yes ___ No ___

Grind their teeth? Yes ___ No ___

Clench their jaw? Yes ___ No ___

Authorization & 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 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 payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental 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 parent or guardian: _____ Date _____