

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 \_\_\_\_\_  
Sex \_\_\_\_\_  
Birth date \_\_\_\_\_  
SS # \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_  
SS # \_\_\_\_\_  
DL # \_\_\_\_\_  
Home phone \_\_\_\_\_  
Cell phone \_\_\_\_\_

## Mother Stepmother Guardian

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birth date \_\_\_\_\_  
SS # \_\_\_\_\_  
DL # \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  
 Widowed  Separated

## Father Stepfather Guardian

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Birth date \_\_\_\_\_  
SS # \_\_\_\_\_  
DL # \_\_\_\_\_  
Marital Status:  Single  Married  Divorced  
 Widowed  Separated

## Primary Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Ins I.D. # \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Ins I.D. # \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
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 \_\_\_\_\_

What medication 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 \_\_\_\_\_

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 \_\_\_\_\_