

# 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 your child.

## PATIENT INFORMATION

Child's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Hobbies/Sports \_\_\_\_\_

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

Notify in case of emergency \_\_\_\_\_ Home Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

## PRIMARY INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Child \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_ Insurance Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

## ADDITIONAL INSURANCE

Is child covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from child) \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Email \_\_\_\_\_ Insurance Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of other dependents under this plan \_\_\_\_\_

Please complete both sides.

## DENTAL HISTORY

What would you like us to do for your child today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Dentist's Email \_\_\_\_\_ Phone \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Does your child experience pain or discomfort in the jaw joint?  Y  N

Has your child ever experienced a mouth or chin injury?  Y  N

Does your child have speech problems?

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?  Y  N

Child's habits affecting the mouth or teeth:  Thumb sucking  Nail biting  Other \_\_\_\_\_

Other information about your child's dental health or previous treatment \_\_\_\_\_

## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Email \_\_\_\_\_

Date of last visit \_\_\_\_\_ Has your child had any serious illnesses or operations?  Y  N

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

Is your child currently under physician care?  Y  N If yes, describe \_\_\_\_\_

Has your child ever had a blood transfusion?  Y  N If yes, give approximate dates: \_\_\_\_\_

Has your child ever taken Fen-Phen/Redux?  Y  N

Check (✓) yes or no whether your child has had any of the following:

- |                                                                              |                                                                          |                                                                                                                         |                                                                                         |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive      | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood     | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/<br>Abnormal bleeding                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                 | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes           | <input type="checkbox"/> Y <input type="checkbox"/> N Immunizations current                                             | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                 | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy           | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or<br>malfunction                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting           | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease                                                     | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease          | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies     | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies<br>( <b>latex</b> , wool, metal,<br>chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or<br>malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer                 | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches          | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease                                               | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis                       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox            | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever                                           | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy   | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems     |                                                                                                                         | <input type="checkbox"/> Y <input type="checkbox"/> N Other<br>Describe _____           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent      | Describe _____                                                           |                                                                                                                         |                                                                                         |

List medications your child is taking, if any: \_\_\_\_\_

List drug allergies, if any: \_\_\_\_\_

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

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

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**