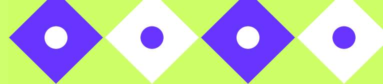
Welcome



About Your Child

Today's Date_____/______/_________

Child's Name_______________________________________

Child's Nickname___________________ ☐ Boy ☐ Girl

Child's Birthdate_____/_____/_______ Age:_______ School:___________________________________
Grade:_____

Child's Home Phone Number ___________________Child's social security #_______________________

Child's Address ____

____

____
CITY STATE ZIP

Referred by Dr.____

Insurance Information

PRIMARY INSURANCE

Company Name____

Address:____

____

Phone Number_________________ Insured's Identification #______________________________

Group #_____________________________ Insured's Name_____________________________

Relationship to patient______________________________________

Date of Birth Insured_______________________ Insured's Employer_______________________________

SECONDARY INSURANCE

Company Name____

Address:____

____

Phone #_____________________________________ Insured's ID #_______________________________

Group #_____________________________(plan, local, or policy #)

Insured's Name_______________________________ Relation ____________________Birthdate__________

Insured's Employer______________________________

PATIENT FAMILY INFORMATION

Who is accompanying this child today? __________________________________Relation to child___________

Do you have legal custody of child? ☐ Yes ☐ No

How many brothers and sisters?_____________ What are their ages?__________________

Mother's Name_____________________________ stepmother, guardian (Circle if applicable)

Mother's address if different from child____

City STATE ZIP

Home Phone_________________________________ Work Phone__________________________

Mother's Social Security Number________________________ Date Of Birth__________________

Driver's License Number______________________________ Employer______________________

How long?_____years Employers Address____

Father's Name_________________________________ _____stepparent, guardian (Circle if applicable)

Father's address____

City STATE ZIP CODE

☐ Check box if same as child. Home Phone_____________ Work phone______________________

Father's social security #___________________________________Father's DOB_________________

Fathers Drivers License #__________________________________ Employer______________________

How long? _________years. Employers address____

ACCOUNT INFORMATION

Person responsible for account

Name____ Relation to patient_____________

Billing Address:____

Social Security #________________________________ Date of Birth___/___/____

Driver's License #______________________________ Work Phone #_____________________

Cell Phone________________________________ Payment Method Cash ☐ Check ☐

☐ Credit Card Type of Card_________ Card Number___________________________________

Exp Date_____/________

_____________(Initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

CHILDS DENTAL INFORMATION

Reason for todays visit : ☐ Exam ☐ Emergency ☐ Consultation

Is your child in pain? ☐ Yes ☐ No If so, How long?____________

Please check any boxes for conditions your child is having now or recently.

- ☐ Discomfort of jaw or clicking/popping
- ☐ Red, swollen, or bleeding gums
- ☐ Sensitive teeth or gums
- ☐ Blisters or sores around mouth
- ☐ Discomfort of jaw clicking or popping
- ☐ Lost or broken fillings
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken or chipped teeth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Loose tooth or teeth

Does your child require antibiotic premedication for dental procedures?________
Previous Dentist:_________________________
Last Dental Exam Date______________________ Last X-Rays_________________
Is your child's water fluoridated?_________ How many times daily does child brush?_________ Times weekly flosses______ What would you rate your child's smile 1 to 10? (A score of ONE being the best)_________

Please indicate with a check in the box if any of the following conditions have ever occurred or are present now for your child.

- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valves
- ☐ Congenital Heart defect
- ☐ Scarlet Fever
- ☐ Surgeries Operations
- ☐ Cancer /Tumors/ Chemotherapy
- ☐ Jaw Problems TMJ TMD
- ☐ Hearing Problems
- ☐ Tonsilitis
- ☐ Respiratory Problems
- ☐ Leukemia /Anemia
- ☐ Diabetes/Hypoglycemia
- ☐ Hemophilia
- ☐ Abnormal Bleeding
- ☐ Cleft Lip/palate
- ☐ Birth defects
- ☐ High/low blood pressure
- ☐ Hepatitis
- ☐ Artificial bones/joints/implants
- ☐ Liver/kidney/organ problems
- ☐ HIV /AIDS / ARC
- ☐ Tuberculosis TB
- ☐ Psychiatric problems
- ☐ Hyperactive ADHD
- ☐ Fainting /Seizures /Epilepsy
- ☐ Asthma/Difficulty Breathing
- ☐ Blood Transfusion
- ☐ Cerebral Palsy

Please indicate any other procedures or conditions your child has had:____

Please indicate if your child is allergic to: ☐ latex ☐ Penicillin /Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics

☐ Novocaine ☐ Food Allergies Other allergies____

Please rate your child's general health from 1-10________ Does your child wear glasses or contact lenses? (Circle one)

Has your child ever taken the drug Ritalin? _________yes/no If so , How long?_________ Child's blood type_______

Does your child do any of the following? ☐ Thumb/finger sucking ☐ Tongue thrusting/sucking ☐ heavy snoring

☐ Mouth breathing ---Nighttime? Daytime? ☐ Lip sucking or biting

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If the account is not paid within ninety days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred collecting on your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. PLEASE SIGN BELOW

X ______________________________ Date ______________