

# 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 any questions we will be glad to help. We look forward to working with you in maintaining your child's dental health.

## Patient information

Date \_\_\_\_\_ SS/Patient ID# \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of minor \_\_\_\_\_ Sex: M or F Age \_\_\_\_\_  
last name first name

Nick Name \_\_\_\_\_ Hobbies \_\_\_\_\_

Home address \_\_\_\_\_  
Street City State Zip

School Name \_\_\_\_\_ School phone \_\_\_\_\_

Person financially responsible \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Work phone \_\_\_\_\_

## Insurance

Father's/Guardian's Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Soc Sec # \_\_\_\_\_ DOB \_\_\_\_\_

Do you have dental coverage for the minor/child \_\_\_ yes \_\_\_ no

Plan Name \_\_\_\_\_ Phone( ) \_\_\_\_\_

Address \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Mother's/Guardian's Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Soc Sec # \_\_\_\_\_ DOB \_\_\_\_\_

Do you have dental coverage for the minor/child? \_\_\_ yes \_\_\_ no

Plan Name \_\_\_\_\_ Phone( ) \_\_\_\_\_

Address \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Is your child eligible for treatment under Medical Assistance? \_\_\_\_yes \_\_\_\_no

Child's Medical Assistance ID# \_\_\_\_\_

**Dental History**

Date of last visit to a dentist \_\_\_\_\_ For what service \_\_\_\_\_

Has child complained about dental problems? Y/N Is fluoride taken in any form? Y/N

Does child brush teeth daily? Y/N Any injuries to mouth, teeth, head? Y/N

Does child use floss every day? Y/N Any unhappy dental experiences? Y/N

Any mouth habits—thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?

**Medical History**

Minor/Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

Is Minor/Child under care of physician now? Y/N Dr. \_\_\_\_\_

Receiving any medication or drugs? Medications \_\_\_\_\_

Ever been hospitalized? \_\_\_\_\_

Ever had surgery? \_\_\_\_\_ Allergies \_\_\_\_\_

Is there excessive bleeding when cut? \_\_\_\_\_

Has minor/child had any history of or difficulty with any of the following? If yes, please circle.

- |                  |                    |                  |                |                 |
|------------------|--------------------|------------------|----------------|-----------------|
| A.I.D.S./H.I.V.  | Cerebral Palsy     | Epilepsy         | Kidney Disease | Rheumatic Fever |
| Anemia           | Chicken Pox        | Fainting         | Liver Disease  | Sinus Problems  |
| Asthma           | Convulsions        | Hearing Problems | Measles        | Thyroid Disease |
| Bladder Problems | Diabetes           | Heart Problems   | Mononucleosis  | Tuberculosis    |
| Cancer           | Drug/Alcohol Abuse | Hepatitis        | Mumps          | Other           |

**Emergency Contact**

In the event of an emergency, whom should we 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 \_\_\_\_\_

Please Print Name of Minor/Child

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 \_\_\_\_\_

Name of Insurance Company(ies)

And assigned 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 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 I completed or one year from the date signed.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative                      Date

\_\_\_\_\_  
Please print name of parent, Guardian or Personal Representative      Relationship to Patient