

# 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 \_\_\_\_\_ Phone \_\_\_\_\_

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

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

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

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

## PRIMARY INSURANCE

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

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

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

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

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 \_\_\_\_\_ Phone \_\_\_\_\_

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

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 \_\_\_\_\_ 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? \_\_\_\_\_

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

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

## MEDICAL HISTORY

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

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 used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva.  Y  N

Check (✓) if your child has had any of the following:

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

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 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.**