Your Child

Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

School _____ Grade _____

Would you prefer to receive appointment confirmations via text and/or email messages? ☐ Yes ☐ No

Email Address _____

Responsible Party Mailing Address _____
Address State Zip

Responsible Party

Name _____

Relationship _____

Home Phone _____

Cell Phone _____

Which number do you prefer to receive calls? _____

Please present your child's picture ID (if available) and/or responsible party's ID.

Email Address _____

Mother ☐ Stepmother ☐ Guardian

Name _____

DOB _____ SS# _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

DOB _____ SS# _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

DOB _____ SS# _____

Insurance Company _____

Employer _____ Date of Hire _____

Group or Plan # _____ Subscriber ID _____

Additional Insurance

Have you or your family had dental claims submitted elsewhere during the benefit year? ☐ Yes ☐ No

Insured's Name _____

DOB _____ SS# _____

Insurance Company _____

Employer _____ Date of Hire _____

Group or Plan # _____ Subscriber ID _____

Please provide us with your dental benefit cards for verification.

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ Discover

☐ I wish to discuss the office's payment financial arrangements.

Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of $2.50 will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

_____
Initial

Dental & Health History

Name _____ DOB _____

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?..... ☐ Yes ☐ No Does your child take fluoride supplements?..... ☐ Yes ☐ No

Does your child:

Suck thumb/finger..... ☐ Yes ☐ No Grind teeth ..... ☐ Yes ☐ No

Suck/Bite lip..... ☐ Yes ☐ No Clench jaws ..... ☐ Yes ☐ No

Bite/Chew nails ..... ☐ Yes ☐ No Gag easily..... ☐ Yes ☐ No

Chew hard objects (pencils, etc.)..... ☐ Yes ☐ No Tonsils/Adenoids removed _____ age ..... ☐ Yes ☐ No

Speech Problem..... ☐ Yes ☐ No

Apprx. date of last dental visit? _____ Previous dentist _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No (if yes, please explain) _____

_____

Previous Hospitalizations/Surgeries/Serious Illnesses?

_____

Is your child currently taking medications?

_____ ☐ Yes ☐ No (if yes, please explain) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs, medications or other substance such as penicillin or latex? ☐ Yes ☐ No (if yes please explain) _____

_____

Has your child ever had any of the following:

Asthma ..... ☐ Yes ☐ No Stomach, liver or kidney problems (circle)..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No Tuberculosis ..... ☐ Yes ☐ No

Hepatitis ..... ☐ Yes ☐ No Diabetes Type I Type II (circle) ..... ☐ Yes ☐ No

HIV ..... ☐ Yes ☐ No Rheumatic Fever ..... ☐ Yes ☐ No

Hemophilia..... ☐ Yes ☐ No Congenital Heart Defect ..... ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ..... ☐ Yes ☐ No

Heart Murmur ..... ☐ Yes ☐ No

Seizures/Epilepsy..... ☐ Yes ☐ No

Hearing Impairment ..... ☐ Yes ☐ No

Acid Reflux ..... ☐ Yes ☐ No Handicap/Disabilities ..... ☐ Yes ☐ No

Please explain any medical problem that your child has: _____

_____

Health History Review: **Initials:**

Date_____ Comments_____ Patient_____ Provider _____

Date_____ Comments_____ Patient_____ Provider _____

Date_____ Comments_____ Patient_____ Provider _____

Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's 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 patient (or parent/guardian if minor) Date

Annual Information Update:

Date_____ No Changes ☐ or Please update the following information _____

_____

Date_____ No Changes ☐ or Please update the following information _____

_____

Date_____ No Changes ☐ or Please update the following information _____

_____