

## Patient Information

Child's name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: (M) (F)

Purpose of visit: \_\_\_\_\_ Concerns: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name and age of brothers/sisters: \_\_\_\_\_ Is your child adopted? Y N

Child's Interests: \_\_\_\_\_ Name of Pet(s): \_\_\_\_\_

Does your child have any special needs? \_\_\_\_\_ Any phobias? \_\_\_\_\_

Allergies? \_\_\_\_\_

Child's learning: slow average accelerated Child's school: \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

### Health History

Child's Pediatrician: \_\_\_\_\_ Phone number : (\_\_\_\_) \_\_\_\_\_ Last Physical: \_\_\_\_\_

Is your child under a physician's care now? Y N If yes, reason: \_\_\_\_\_ Immunization up to date? Y N

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N If yes, please list in the back

Is your child allergic to any medication? Y N If yes, please list: \_\_\_\_\_

Any history of hospitalization or surgery: (if yes, when) \_\_\_\_\_

Has your child had any history or ever been diagnosed with any of the following?

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Allergy/Hay fever      | <input type="checkbox"/> Chemotherapy       | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Attention Deficit Disorder     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Arthritis/ Rheumatism  | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Polio            | <input type="checkbox"/> Behavior/Learning Disabilities |
| <input type="checkbox"/> Autism             | <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Chronic sinusitis  | <input type="checkbox"/> Pregnancy        | <input type="checkbox"/> Bone/Joint/orthopedic problem  |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Artificial joint/limb  | <input type="checkbox"/> Cleft lip/palate   | <input type="checkbox"/> Rheumatic fever  | <input type="checkbox"/> Digestive disturbances         |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Epilepsy/seizure       | <input type="checkbox"/> Eye problems       | <input type="checkbox"/> Scarlet fever    | <input type="checkbox"/> Hearing loss/aids/implants     |
| <input type="checkbox"/> Hemophilia         | <input type="checkbox"/> Birth defects          | <input type="checkbox"/> Growth problem     | <input type="checkbox"/> Scoliosis        | <input type="checkbox"/> Heart problem/surgery          |
| <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Shunt            | <input type="checkbox"/> High/low blood pressure        |
| <input type="checkbox"/> HIV+/AIDS          | <input type="checkbox"/> Brain injury           | <input type="checkbox"/> Kidney problems    | <input type="checkbox"/> Tetanus          | <input type="checkbox"/> Hormonal disturbances          |
| <input type="checkbox"/> Measles            | <input type="checkbox"/> Brain surgery          | <input type="checkbox"/> Liver problems     | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Malignant hyperthermia         |
| <input type="checkbox"/> Mumps              | <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Whooping cough                 |
| <input type="checkbox"/> Cancer, type _____ |   | <input type="checkbox"/> Other _____        |   |   |

### Dental History

Is this your child's first dental visit? Y N If no, previous dentist: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Date of last visit: \_\_\_\_\_ How was his/her experience? \_\_\_\_\_ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: \_\_\_\_\_

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: \_\_\_\_\_

Has your child done any of the following (past or present)? Please check:

thumb/finger-sucking    pacifier    nail biting    lip sucking    mouth-breathing    snoring    teeth grinding    nursing    bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? \_\_\_\_\_ With adult supervision? Y N How often does your child floss? \_\_\_\_\_

How may we help to make this visit a positive experience for your child? \_\_\_\_\_

For families with reverse osmosis filtration or in an unfluoridated area, are you interested in a fluoride supplement? Y N



**Patient Information**

**General Information**

Father (full name) \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Mother (full name) \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Parent(s) are: Married \_\_\_ Divorced \_\_\_ Single \_\_\_ Widowed \_\_\_ Partners \_\_\_ Child lives with: both parents mother father other Home

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Street

City

Zip

Father's Employer: \_\_\_\_\_ Cellular Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Cellular Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Person financially responsible for child's dental care: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

How would you like us to contact you? Home Work Cell E-mail

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Information**

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address of Father's Insurance Company: \_\_\_\_\_

Mother's Insurance Company: \_\_\_\_\_ Group Number \_\_\_\_\_

Address of Mother's Insurance Company: \_\_\_\_\_

**Financial Agreement**

**For patients with dental insurance:** I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of \$25 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion the day of dental treatment.

**For patients without insurances:** payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of \$25 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

SIGNATURE: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_