

thank you for selecting us.

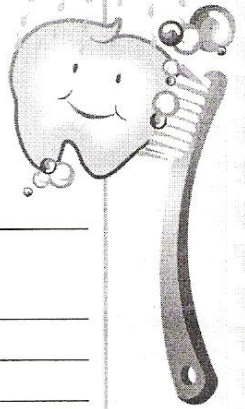
Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____
 Nickname _____ Social Security # _____ Birthdate _____
 School _____ Grade _____
 Child's Home Address _____
 City, State, Zip _____ Phone _____



Responsible Party

Name _____ Relationship _____
 Address _____
 City, State, Zip _____ Phone _____
 Social Security # _____ DL# _____
 Who is Responsible for Making Appointments? _____

Parent or Guardian Information

Mother Stepmother Guardian

Name _____
 Home Phone _____ Work Phone _____
 Employer _____ Occupation _____
 Social Security # _____ DL # _____
 Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father Stepfather Guardian

Name _____
 Home Phone _____ Work Phone _____
 Employer _____ Occupation _____
 Social Security # _____ DL # _____
 Marital Status Single Married Separated Divorced Widowed

Primary Insurance

Insured's Name _____ Relationship _____
 Birthdate _____ Social Security # _____
 Employer _____ Date Employed _____ Occupation _____
 Insurance Co. _____ Group # _____ Employee # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____
 Birthdate _____ Social Security # _____
 Employer _____ Date Employed _____ Occupation _____
 Insurance Co. _____ Group # _____ Employee # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please



Dental/Medical Health History (Confidential)

Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

How often does your child floss? _____

Child attitude to dentistry _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Clench Jaws Yes No

Has your child had difficulty with previous dental visits? Yes No

Do you desire complete dental service for the child _____ Yes No

Has your child ever had any of the following:

Abnormal Bleeding Yes No

Anemia Yes No

Asthma Yes No

Bladder Yes No

Cancer Yes No

Cerebral Palsy Yes No

Chicken Pox Yes No

Chronic Sinus Yes No

Congenital Heart Defect Yes No

Convulsions/Epilepsy Yes No

Diabetes Yes No

Epilepsy Yes No

Fainting Yes No

Handicaps/Disabilities Yes No

Hearing Yes No

Heart Yes No

Heart Murmur Yes No

Hemophilia Yes No

Hepatitis Yes No

HIV/AIDS Yes No

Date of Last Dental Visit _____

For what service _____

Previous Dentist _____

Address _____

Has child complained about dental problems _____ Yes No

Any injuries to mouth - teeth - head _____ Yes No

Any unusual speech habits _____ Yes No

Any lost teeth _____ Yes No

Have missing teeth been replaced _____ Yes No

Orthodontic appliances worn now or ever been _____ Yes No

Do you assist child with tooth brushing _____ Yes No

How often _____

Is dental floss used _____ Yes No

How often _____

Are disclosing tablets used _____ Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Malignancies Yes No

Mastoid Yes No

Measles Yes No

Mononucleosis Yes No

Mumps Yes No

Rheumatic Fever Yes No

Stomach, Liver or Kidney Problems Yes No

Thyroid Yes No

Tuberculosis Yes No

Veneral Disease Yes No

Other Yes No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Is your child currently taking any medications? Yes No (if yes, please list _____)

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option your prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care 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 Guardian, if minor _____ Date _____

Dentist's Review: _____

Signature of Dentist _____ Date _____