

# WELCOME

1

## About Your Child

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ File #: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
LAST FIRST M.I.

Child's Nickname: \_\_\_\_\_  Boy  Girl

Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Home Phone #: (\_\_\_\_) \_\_\_\_\_

Child's SS#: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
HOME ADDRESS

CITY STATE ZIP

Referred By: \_\_\_\_\_  
(If doctor, please give address & phone number.)

2

## Insurance Information

### Primary Dental Insurance

Co. Name: \_\_\_\_\_

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

CITY STATE ZIP

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

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

Does either policy cover Orthodontics?  Yes  No

### Secondary Dental Insurance

Co. Name: \_\_\_\_\_

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

CITY STATE ZIP

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

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_

3

## Child's Family Information

Who is accompanying this child today?

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child?  Yes  No

How many Brothers/Sisters? \_\_\_\_\_ Age(s): \_\_\_\_\_

MOTHER'S NAME  STEP MOTHER  GUARDIAN EMAIL ADDRESS

CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

(\_\_\_\_) (\_\_\_\_)  
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME  STEP FATHER  GUARDIAN EMAIL ADDRESS

CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

(\_\_\_\_) (\_\_\_\_)  
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

EMPLOYER'S ADDRESS CITY STATE ZIP

4

## Account Information

Person ultimately responsible for account

Name: \_\_\_\_\_ RELATION TO CHILD

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

CITY STATE ZIP

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(\_\_\_\_) (\_\_\_\_)  
WORK PHONE #: EXT. CELL PHONE #:

Payment method:  Cash  Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5

### Child's Dental Information

Reason for today's visit:  Exam  Emergency  Consultation

Is Child in pain?  No  Yes How Long? \_\_\_\_\_

Please indicate  any of the following problems:

- Discomfort, clicking or popping in jaw.     Lost/Broken Filling(s)     Stained teeth
- Red, swollen or bleeding gums.             Teeth grinding                     Locking Jaw
- Sensitive tooth, teeth or gums.             Ringing in Ears                     Bad breath
- Blisters/Sores in or around the mouth.     Broken/Chipped tooth     Loose tooth
- Other(s): \_\_\_\_\_

Does child require pre-medication?  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

Last Dental exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental X-rays: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Times a day child brushes? \_\_\_\_\_ Times a week child flosses? \_\_\_\_\_

Is the child's water fluoridated?  Yes  No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6

### Child's Medical History

Is Child taking any of the following medications?  Pain killers (INCLUDING ASPIRIN)  Ritalin  Stimulants  
 Blood Thinners  Tranquilizers  Insulin  Muscle relaxers  Others: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
DOCTOR'S NAME OR CLINIC NAME PHONE#

ADDRESS CITY STATE ZIP Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### Does Child have or ever had any of the following diseases, medical conditions or procedures?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Tonsillitis                 | <input type="checkbox"/> High/Low Blood Pressure          |
| <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Respiratory Problems        | <input type="checkbox"/> Hepatitis                        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Artificial Bones/Joints/Implants |
| <input type="checkbox"/> Congenital Heart defect | <input type="checkbox"/> Blood Transfusion(s)        | <input type="checkbox"/> Liver/Kidney/Organ Problems      |
| <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Leukemia/Anemia             | <input type="checkbox"/> HIV+/AIDS/ARC                    |
| <input type="checkbox"/> Surgeries/Operations    | <input type="checkbox"/> Diabetes/Hypoglycemia       | <input type="checkbox"/> Tuberculosis TB                  |
| <input type="checkbox"/> Cancer/Tumors           | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Psychiatric Problems             |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Abnormal Bleeding           | <input type="checkbox"/> Hyper Active/ADD                 |
| <input type="checkbox"/> Jaw Problems TMJ/TMD    | <input type="checkbox"/> Cleft Lip/Palate            | <input type="checkbox"/> Fainting/Seizures/Epilepsy       |
| <input type="checkbox"/> Hearing Problems        | <input type="checkbox"/> Birth Defects               | <input type="checkbox"/> Cerebral Palsy                   |

Please list any other medical condition(s) child has or ever had: \_\_\_\_\_

Is Child allergic to:  Latex  Penicillin/Amoxicillin  Tetracycline  Dental Anesthetics (Novocaine)  
 Aspirin  Food allergies  Other(s): \_\_\_\_\_

Please rate the child's general health from 1-10: \_\_\_\_\_ Does child wear contact lenses?  Yes  No

Has this child ever taken the drug Ritalin?  No  Yes/How long? \_\_\_\_\_ Child's Blood type: \_\_\_\_\_

Does this child do any of the following?  Thumb/Finger Sucking  Tongue Thrusting/Sucking

Heavy Snoring  Mouth Breathing  Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Parent or Guardian  Other:

#### UPDATE (OFFICE USE)

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date

Comments