

# 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.)

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 \_\_\_\_\_

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: \_\_\_\_\_

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)

Initials \_\_\_\_\_ 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

Reason for today's visit:  Exam  Emergency  Consultation

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

Please indicate  any of the following problems:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Discomfort, clicking or popping in jaw. | <input type="checkbox"/> Lost/Broken Filling(s) | <input type="checkbox"/> Stained teeth |
| <input type="checkbox"/> Red, swollen or bleeding gums.          | <input type="checkbox"/> Teeth grinding         | <input type="checkbox"/> Locking Jaw   |
| <input type="checkbox"/> Sensitive tooth, teeth or gums.         | <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Bad breath    |
| <input type="checkbox"/> Blisters/Sores in or around the mouth.  | <input type="checkbox"/> Broken/Chipped tooth   | <input type="checkbox"/> Loose tooth   |
| <input type="checkbox"/> 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

### 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#

Last Medical Exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

ADDRESS

CITY

STATE

ZIP

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

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

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent or Guardian  Other: \_\_\_\_\_

UPDATE  
(OFFICE USE)

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

Comments \_\_\_\_\_

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

Comments \_\_\_\_\_

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

Comments \_\_\_\_\_