GET ACQUAINTED QUESTIONNAIRE

Date _____

Child's Name _____ ☐ M ☐ F Age _____ Date of Birth _____
Mailing Address _____ Social Security # _____
City _____ State _____ Zip _____ Home Phone _____
Father's Name _____ Date of Birth _____ Social Security # _____
Foster Dad _____
Driver's License # _____ Employer Name & Address _____
Business Phone _____ Present Position _____
Cell Phone _____
Mother's Name _____ Date of Birth _____ Social Security # _____
Foster Mom _____
Driver's License # _____ Employer Name & Address _____
Business Phone _____ Present Position _____
Cell Phone _____
Other person responsible for this account _____
Social Security # _____ Driver's License # _____
Employer Name & Address _____ Business Phone _____
Insurance Name _____ Group # _____
Who referred you? _____ Their Address _____
What is child's favorite: Sport _____ Toy _____ Hobby _____ Nickname _____

HEALTH HISTORY

A. DENTAL

Date of last visit to a dentist _____
Has your child complained about dental problems? YES NO
Have there been any unhappy dental experiences? YES NO
Any injuries to mouth-teeth-head? YES NO
Has your child any history of:
- Thumbsucking YES NO
- Fingersucking YES NO
- Lip Biting YES NO
- Nail Biting YES NO
- Tongue Thrusting YES NO

Nurse/Bottle Habits/Sippy Cup YES NO
Does your child brush teeth daily? YES NO
Does your child let you help with tooth brushing? YES NO
Does your child let you assist with flossing? YES NO
Is fluoride taken in any other form than in toothpaste? YES NO

Child's attitude to dentist _____
Do you desire complete dental service for your child? YES NO
Has orthodontic treatment been recommended? YES NO

B. MEDICAL

Is your child in good health? YES NO
Comments _____
Does your child have regular medical exams? YES NO
Date of last exam _____
Reason for exam _____

Were there any problems with the birth of this child? YES NO

Is your child taking any medication? YES NO
If so, what? and why? _____

Is your child allergic to latex? YES NO

Has your child ever experienced an unfavorable or allergic reaction to drugs including antibiotics (Penicillin) & local anesthetics or other drugs? YES NO

In the learning process, would you classify your child as:
Above average Average Below average
Comments _____

Has child any history or difficulty with any of the following?

YES NO Tuberculosis	YES NO Chronic Sinus	YES NO Bedwetting	YES NO Cerebral Palsy
YES NO Bladder Problems	YES NO Heart	YES NO Diabetes	YES NO Hearing Problems
YES NO Epilepsy	YES NO Rheumatic Fever	YES NO Liver Problems	YES NO Frequent Nose Bleeds
YES NO Cancer	YES NO Asthma	YES NO Mononucleosis	YES NO Pregnancy
YES NO Hepatitis	YES NO Kidney Problems	YES NO Speech Problems	YES NO Aids-HIV
YES NO Bleeding Disorder	YES NO Convulsions	YES NO ADHD/ADD	YES NO Down Syndrome or any other genetic defect _____
YES NO Fainting Spells	YES NO Seizures	YES NO Autism	
YES NO Behavior Problems	YES NO Mastoid Problems	YES NO Depression	
YES NO Anemia	YES NO Thyroid Problems	YES NO Chronic Chest Congestion	Other: _____

Family Physician or Pediatrician _____
Address _____ Phone # _____
Are other family members under our care? Name _____
Family history of general anesthesia problems, hospitalization _____

For Prompt filing of dental claims please fill out the following information completely if it applies.
Thank you for your help.

Dental Insurance Company _____ Policy Holder - Mr. or Mrs.
Policy Holder's S.S. # _____
Address where claims are to be sent _____ City _____ State _____
Group # _____ Subscriber or I.D. # _____
Is patient covered by another dental plan? _____ Name _____

FINANCIAL STATEMENT:

Normally, payment for dental treatment is expected when services are performed. We accept checks, cash, or credit card. If you have dental insurance, we will be happy to file any claims, however, you are still responsible for your account. Dental insurance coverage on your child rarely covers all expenses. Obligation for payment still belongs to you. You will receive a statement each month - accounts are due and payable monthly as work progresses, regardless of insurance coverage. Any overpayment on your account will be refunded to you when your child's dental work is completed.

Any account delinquent over 30 days will be turned over to a collection agency. There is a charge on all returned checks and any check not paid in cash on demand will be turned over to the district attorney for prosecution.

In order to make ideal dental care available to as many of our patients as possible, on more extensive cases we will submit a pre-determination of benefits to the insurance company.

EXAM: A routine dental exam may include 1.) oral examination, 2.) reading of dental x-rays, 3.) a dental cleaning with topical fluoride, 4.) a consultation with the pediatric dentist. All X-Rays are property of this office.

Signature _____ Date _____

BECAUSE YOUR CHILD IS A MINOR AND TO COMPLY WITH THE NEW LAW FROM THE STATE BOARD OF DENTAL EXAMINERS OF TEXAS, IT BECOMES NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY DENTAL TREATMENT BE STARTED AND ACCOMPLISHED.

THIS SIGNED CONSENT FORM INDICATES THAT THE FOLLOWING HAS BEEN ACCOMPLISHED:

1. The parent or guardian has been explained the treatment plan and methods to be utilized.
2. The parent or guardian has been explained the drugs to be utilized for this treatment.
3. The parent or guardian has been given the different treatment options to include no treatment.
4. The parent or guardian has been explained the post-operative course and possibility of complications.
5. If your child requires conscious sedation, a separate consent form will be required for treatment.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental services, and the use of appropriate methods. This consent shall remain in full force and effect until cancelled by either party.

Signature _____ Date _____

IF YOU RECEIVE ASSISTANCE FROM WELFARE / MEDICAID

YOU MUST HAVE A CURRENT MEDICAID CARD for a regular or emergency dental exam. It is also necessary for us to make a copy of your Medicaid card, please present it with this questionnaire and each time your child is seen by the dentist. If you do not bring your card each time, you are responsible for any charges when your child is treated. Please notify us if you become ineligible for these benefits.

Name:_____ Date:_____

Patient Dental History

Please answer the following questions:

Describe child's brushing habits? _____

Is your child's water fluoridated?	☐ Yes ☐ No
Is your child taking fluoride supplements?	☐ Yes ☐ No
Do your child's gums bleed while brushing or flossing?	☐ Yes ☐ No
Do you have any areas of concerns?	☐ Yes ☐ No
Has your child had any injuries to his or her mouth, teeth, or head?	☐ Yes ☐ No
Has your child ever experienced clicking or pain of the jaw?	☐ Yes ☐ No
Has your child ever experienced difficulty opening, closing, or chewing?	☐ Yes ☐ No
Does your child breathe through his or her mouth?	☐ Yes ☐ No
Does your child have frequent headaches?	☐ Yes ☐ No
Has child had a negative experience with previous dental visits?	☐ Yes ☐ No
Is this your child's first visit to the dentist?	☐ Yes ☐ No

Other Comments? _____

Please answer the following questions:

Does your child clinch or grind his or her teeth?
☐ Yes ☐ No If yes? _____

Do you assist your child while flossing and brushing?
☐ Yes ☐ No If no? _____

Are you pleased with the appearance of your child's smile?
☐ Yes ☐ No If no? _____

Has the mother or primary caregiver had cavities in the past 12 months?
☐ Yes ☐ No If yes? _____

Does your child sleep with a bottle at night?
☐ Yes ☐ No If yes? _____

Does your child's bottle or sippy cup contain fluid other than milk or water?
☐ Yes ☐ No If yes? _____

Does your child suck his or her thumb and/or fingers?
☐ Yes ☐ No If yes? _____

Does your child bite his or her nails?
☐ Yes ☐ No If yes? _____

Does your child drink sodas?
☐ Yes ☐ No If yes? _____

Has your child ever had dental X-rays?
☐ Yes ☐ No If yes? _____

Has your child ever had general anesthesia?
☐ Yes ☐ No If yes? _____

Has a family member ever had a problem with general anesthesia?
☐ Yes ☐ No If yes? _____

Name:_____ Date:_____

Patient Medical History

Physician: _____Office Phone: _____

Routine Exam? ☐ Yes ☐ No Is your child under medical Treatment now? ☐ Yes ☐ No

Has you child been hospitalized for surgery or serious illness? ☐ Yes ☐ No
If yes, explain: _____

Does your child have or has your child had any of the following?

Fainting	☐ Yes ☐ No	Kidney or Liver Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No		
Epilepsy	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	DS or HIV	☐ Yes ☐ No		
Seizures	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No		
Bleeding Disorder	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No		
Sickle Cell	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No	Bones/Joints	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No	Hearing Impairment	☐ Yes ☐ No	Growth Prob	☐ Yes ☐ No		
Blood Transfusion	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Speech	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Pregnancy	☐ Yes ☐ No		
		Rhuematic Fever	☐ Yes ☐ No				

Comments: _____

Does your child have or has had any of the following?

Sleep Apnea	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autism	☐ Yes ☐ No
Acid Reflux	☐ Yes ☐ No	ADD/ADHD	☐ Yes ☐ No	Cerebral Palsy	☐ Yes ☐ No
Other	☐ Yes ☐ No	_____			

Is your child taking any medications (including herbal and non-prescription medicines)? ☐ Yes ☐ No
If yes, list medications and dosages? _____

If you child has asthma, when as his or her last episode?_____

Is your child allergic to any of the following: (Please place a check beside which ones)

☐ Aspirin ☐ Latex ☐ Iodine ☐ Sulfa Drugs ☐ Red Dye ☐ Penicillin or other Antibiotics
☐ None ☐ Other: _____

Authorization, Release, & Agreement to Pay for Services Rendered

- I authorize the dentist to release any information including the diagnosis and the records of any treatment examination rendered to me to third party payers and/or health practitioners.
- I authorize and hereby request my insurance company to pay directly to the dentist (or the dental practice) insurance benefits that otherwise are payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services.
- I agree to be responsible for all services rendered on my behalf or on behalf of my dependants.
- I certify that I have read and understand the above information. To the best of my knowledge, the above answers have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

Signature:_____Date:_____