

### About Your Child

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Last, First MI (Preferred Name)

Gender: M / F Birth Date: \_\_\_\_\_ Email: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

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

Hobbies/Sports: \_\_\_\_\_

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

Street

Apartment #

City

State

Zip Code

### Mother's Information

Please circle the following: Are you the Mother/Step-Mother/Legal Guardian

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Father's Information

Please circle the following: Are you the Father/Step-Father/Legal Guardian

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Health and Dental Information

Child's Physician: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_ Last Visit \_\_\_\_\_

Please list all medications your child is currently taking: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

When was the date of your last Full Mouth set of X-Rays \_\_\_\_\_

Are you apprehensive about dental treatment

Yes or No

Have there been any injuries to the face, mouth, teeth or chin

Yes or No

Has your child been informed of any missing or extra permanent teeth

Yes or No

Has your child ever had any pain/tenderness in his/her jaw joint

Yes or No

Have you ever worn BRACES on your teeth

Yes or No

Name of Previous

Dentist: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone

Number: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____   | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Head Injuries       | Due date: _____                               | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Latex Allergy      |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever      | OTHER:                                      |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> _____              |
|  | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |   |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

**Referral Information**

- Whom may we thank for referring you to our practice?  Another patient, friend,  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
 Name of person or office referring you to our practice: \_\_\_\_\_

**Insurance Information**

**Primary**

Insurance Co and Phone: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_  
Last First MI  
 Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

**Secondary**

Insurance Co and Phone: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Subscriber's Birth Date: \_\_\_\_\_  
Last First MI  
 Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

### Consent for Services

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence per HIPPA regulations.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Signature of guarantor of payment/responsible party**