PATIENT INFORMATION

DATE ______________________

CHILD'S NAME ____ SEX _____ DOB ____/____/____ PHONE ___________________
LAST FIRST M

ADDRESS ____
STREET APT.# CITY STATE ZIP

FATHER'S NAME ____ DOB ____/____/____ SS#______________________________
LAST FIRST M

ADDRESS ____
STREET APT.# CITY STATE ZIP

NAME OF EMPLOYER _________________________________ ADDRESS ____

MOTHER'S NAME ____ DOB ____/____/____ SS#______________________________
LAST FIRST M

ADDRESS ____
STREET APT.# CITY STATE ZIP

NAME OF EMPLOYER _________________________________ ADDRESS ____

PERSON RESPONSIBLE FOR ACCOUNT – PLEASE CHECK ONE:
☐FATHER ☐MOTHER ☐GUARDIAN ☐MEDICAID ☐OTHER

E-MAIL ADDRESS:
____
(To be used for appointment confirmations and/or office promotions…your e-mail address will NOT be sold)

WHO HAS LEGAL CUSTODY ______________________________

INSURANCE INFORMATION

MINOR CHILD – MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	SECONDARY INSURED
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL	HOME WORK CELL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO	EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

Is your child covered by **Medicaid**? ☐Yes ☐No If yes, Recipient # ____

Has any member of your family ever been treated in our office ? ☐Yes ☐No

Whom may we thank for referring you to our office ? ____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME ____ TELEPHONE ___________________________

ADDRESS ____
STREET APT.# CITY STATE ZIP

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No
☐Payment in full at each appointment (cash or personal check)
☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)
Card # _____________________________ Exp. Date _________
☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ____% per month (or a minimum charge of $_____ for a balance under $______) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

AUTHORIZATION

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X ____
Patient or Responsible Party

____
Date State Driver's License #

Please complete this medical/dental history of your child. Please use ink. Thank you.

PATIENT NAME ________________________________ **SEX**___ **BIRTHDATE** __________________
(Please Print) Last First Initial

DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-Rays ______________________

Address of previous dentist ____

How did you find out about our office? ____

Are you satisfied with your child's smile? ☐Yes ☐ No If not, are you interested in a consult about braces? ☐Yes ☐ No

How often does your child floss? ______________________ How often does your child brush? ______________________

Check (✓) if you have had problems with the following:

- ☐ Bad breath
- ☐ Drinking water fluoridated
- ☐ Grinding Teeth
- ☐ Injury to head, face, teeth
- ☐ Thumb/Finger/Pacifier Habit
- ☐ TMJ

Is Child Adopted? ☐Yes ☐ No Has your child ever had a previous bad experience with a Dentist? ☐Yes ☐ No

If Yes, please explain ____

MEDICAL HISTORY

Child's Physician's ______________________ Phone Number ______________________

Address ______________________ Date last seen ____________ Reason ____________

Names and ages of siblings ______________________ Are they patients of The Dental Center? ? ☐Yes ☐ No

List any allergies to medication, food, latex or other ____

List any medications the child is currently taking ____

Pharmacy ______________________ Phone Number ______________________

Has your child been treated in the Emergency Room? ____________ If yes, please explain why ______________________

Check (✓) if your child has had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve or Joints
- ☐ Asthma
- ☐ Behavior/Learning Problem
- ☐ Blood Disease/Transfusion
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Ear Aches (Frequent)
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Eye Disorder
- ☐ Fainting
- ☐ Headaches (Frequent)
- ☐ Hearing Disorder
- ☐
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Delay
- ☐ Presently Pregnant
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shunt
- ☐ Skin Rash
- ☐ Sore Throats (Frequent)
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer

☐ OTHER ____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my child's doctor if my minor child ever has a change in health.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________ ______________
PLEASE PRINT NAME of Patient, Parent, Guardian or Personal Representative Relationship to Patient

______________________________ ______________
Signature of Doctor Date