WELCOME

TO CHESTER FAMILY DENTAL CARE, LLC

Today's Date _____ *File #*_____

Child's Name: _____
Last *First*

Child's Nickname: _____ ☐ *Boy* ☐ *Girl*
Child's Birthdate: ____/____/_____ *Age:* _____
Child's SS# _____-_____-_____
Child's home Address: _____

_____
City *State* *Zip Code*
Child's Home Phone #:

_____
Child's School: _____
Referred by: _____

Child's Family Information

Who brought the child in today?

_____
Full name **Relation to the child**
Are you the child's legal guardian? ☐ Yes ☐ No
Mother's Name: _____
☐ Stepmother ☐Guardian
Address (if different from child): _____

_____
City *State* *Zip Code*
*Home Phone #:*_____
*Work Phone#:*_____
*Cell Phone#:*_____
Mother SS#:_____-_____-_____
*Date of Birth:*____/_____/_____
*Employer:*_____*How long?*_____
*Employer address:*_____

_____
City *State* *Zip Code*

_____

Father's Name: _____
☐ Stepfather ☐Guardian
Address (if different from child): _____

_____
City *State* *Zip Code*
*Home Phone #:*_____
*Work Phone#:*_____
*Cell Phone#:*_____
Father SS#:_____-_____-_____
*Date of Birth:*____/_____/_____
*Employer:*_____*How long?*_____
*Employer address:*_____

_____
City State Zip Code

Insurance Information

Primary Dental Insurance Company

*InsuranceName:*_____
*Address:*_____

_____
City *State* *Zip Code*
*Phone #:*_____
*Insured SS#:*_____-_____-_____
*Insured Name:*_____
*Relation:*_____
Group Plan# *(Plan,Local or Policy)*_____
*Date of Birth:*____/____/_____
*Insured's Employer:*_____

Secondary Dental Insurance

*Name:*_____
Address : _____

_____
City *State* *Zip Code*
*Phone #:*_____
*Insured SS#:*_____-_____-_____
*Insured Name:*_____
*Relation :*_____
Group Plan# *(Plan,Local or Policy)*_____
*Date of Birth:*____/____/_____
*Insured's Employer:*_____

****Does either policy cover Orthodontics?***
☐ **Yes** ☐ **No**

Account Information-

Person to be responsible for the account.

Name:_____
*Relation to child:*_____
*Billing Address:*_____

_____
*Home Phone #:*_____
*Work Phone #:*_____
*Cell Phone #:*_____

Payment Method:

☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Care Credit**

I hereby authorize assignment of my insurance rights and benefits directly to the provider for the services rendered. I full understand I am solely responsible for any balance not paid by my insurance company. _____ (Initials)

Child's Dental Information _____

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation
*Is Child in pain: ☐ Yes ☐ No If yes, how long?*_____
Please indicate ☐ any of the following problems:

☐ Broken/Chipped Tooth *☐ Loose Tooth*
☐ Discomfort Popping jaw *☐ Lost/Broken Tooth*
☐ Stained teeth *☐ Teeth grinding*
☐ Red, swollen or bleeding gums *☐ Locking jaw*
☐ Sensitive teeth, tooth, or gums *☐ Ringing in the ears*
☐ Blisters/sores in or around the mouth *☐ Bad Breath*
*☐ Other*_____

Previous Dentist? _____*Phone #:*_____
*Last Dental Exam:*___/___/_____ *Last Dental X-rays* ___/___/_____
*Times per day your child brushes?*_____ *Times per week your child flosses?*_____
What type of tooth brush does your child use: ☐ Soft ☐ Medium ☐ Hard
Is your child's water fluoridated? ☐ Yes ☐ No
How would you rate your child's smile? (best) 12345678910 (worst)

Child's Medical History _____

Is the child taking any of the following medications? ☐ Pain killer (including aspirin) ☐ Ritalin ☐ Stimulants
☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin
*☐ Other(s), please list:*_____
*Child's Physician:*_____*Phone #:*_____
*Last medical exam:*_____
Does your child have or have had any of the following diseases, medical conditions or procedures?

Y N Abnormal bleeding	**Y N** Diabetes/ Hypoglycemia	**Y N** Respiratory Problems
Y N Anemia/Leukemia	**Y N** Fainting/Seizures/ Epilepsy	**Y N** Rheumatic Fever
Y N Arthritis/Rheumatism	**Y N** Hearing Problems	**Y N** Scarlet Fever
Y N Asthma/Difficulty Breathing	**Y N** Heart Murmur	**Y N** Severe/Frequent Headaches
Y N Artificial Bones/Joint/Implants	**Y N** Hemophilia	**Y N** Sinus Problems
Y N Artificial Heart Valves	**Y N** Hepatitis	**Y N** Stomach Problems/Ulcer
Y N Birth defects	**Y N** High/Low Blood Pressure	**Y N** Surgeries/Operations
Y N Blood Transfusions	**Y N** HIV+/AID/RC	**Y N** Thyroid Problems
Y N Cancer/Tumors	**Y N** Hyperactive/ADD/ADHD	**Y N** Tonsillitis
Y N Cerebral Palsy	**Y N** Jaw Problems TMJ/TMD	**Y N** Tuberculosis TB
Y N Chemotherapy	**Y N** Liver /Kidney/Organ Problems	
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	
Y N Cleft Lip/ Palate	**Y N** Psychiatric Problems/Nervousness	
Does your child require pre-medication before dental treatment? ☐ *Yes* ☐ *No* ☐ *Don't know*		

*Please list any other surgeries or medical conditions your child has ever had*_____
_____
Is your child allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Antibiotics ☐ Tetracycline ☐ Aspirin
*☐ Dental Anesthetics (Novacaine) ☐ Food Allergies ☐ Other:*_____
Does your child do any of the following? ☐ Mouth breathing, ☐ Heavy Snoring ☐ thumb/Finger Sucking ☐ Lip Sucking/Biting
☐ Tongue Thrusting/Sucking Please rate your child's health from 1-10 _____

• 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 your 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 of any changes to the information I have provided.
I here 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. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney's fees, court costs or interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service._____ (initials)

Signature_____ Date____/____/_____