

# WELCOME

## Your Child

Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Would you prefer to receive appointment confirmations via text and/or email messages?  Yes  No  
Email Address \_\_\_\_\_  
Responsible Party Mailing Address \_\_\_\_\_  
Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Which number do you prefer to receive calls? \_\_\_\_\_

**Please present your child's picture ID (if available) and/or responsible party's ID.**

Email Address \_\_\_\_\_

## Mother

Stepmother  Guardian

Name \_\_\_\_\_  
DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

## Father

Stepfather  Guardian

Name \_\_\_\_\_  
DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Marital Status**  Single  Married  Partner  Divorced  
 Widowed  Separated

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## Primary Insurance

Have you or your family had dental claims submitted elsewhere during the benefit year?  Yes  No

Insured's Name \_\_\_\_\_  
DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Employer \_\_\_\_\_ Date of Hire \_\_\_\_\_  
Group or Plan # \_\_\_\_\_ Subscriber ID \_\_\_\_\_

## Additional Insurance

**Please provide us with your dental benefit cards for verification.**

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

Cash  Personal Check  
Credit Card  Visa  MC  Discover

I wish to discuss the office's payment financial arrangements.

## Late Charges

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of \$2.50 will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

\_\_\_\_\_  
Initial

**Dental & Health History**

Name \_\_\_\_\_ DOB \_\_\_\_\_

How often does your child brush? \_\_\_\_\_  
Is your child's water fluoridated?.....  Yes  No  
Does your child:  
Suck thumb/finger.....  Yes  No  
Suck/Bite lip.....  Yes  No  
Bite/Chew nails.....  Yes  No  
Chew hard objects (pencils, etc.).....  Yes  No

How often does your child floss? \_\_\_\_\_  
Does your child take fluoride supplements?.....  Yes  No  
Grind teeth.....  Yes  No  
Clench jaws.....  Yes  No  
Gag easily.....  Yes  No  
Tonsils/Adenoids removed \_\_\_\_\_ age.....  Yes  No  
Speech Problem.....  Yes  No

Apprx. date of last dental visit? \_\_\_\_\_ Previous dentist \_\_\_\_\_  
Has your child had difficulty with previous dental visits?  Yes  No (if yes, please explain) \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses?  
\_\_\_\_\_

Is your child currently taking medications? \_\_\_\_\_  Yes  No (if yes, please explain) \_\_\_\_\_

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs, medications or other substance such as penicillin or latex?  Yes  No (if yes please explain) \_\_\_\_\_

Has your child ever had any of the following:

Asthma.....  Yes  No Stomach, liver or kidney problems (circle).....  Yes  No  
Cancer.....  Yes  No Tuberculosis.....  Yes  No  
Hepatitis.....  Yes  No Diabetes Type I Type II (circle).....  Yes  No  
HIV.....  Yes  No Rheumatic Fever.....  Yes  No  
Hemophilia.....  Yes  No Congenital Heart Defect.....  Yes  No  
A persistent cough or throat clearing  
not associated with a known illness  
(lasting more than 3 weeks).....  Yes  No Heart Murmur.....  Yes  No  
Acid Reflux.....  Yes  No Seizures/Epilepsy.....  Yes  No  
Hearing Impairment.....  Yes  No  
Handicap/Disabilities.....  Yes  No

Please explain any medical problem that your child has: \_\_\_\_\_

**Health History Review:**

**Initials:**

Date _____	Comments _____	Patient _____	Provider _____
Date _____	Comments _____	Patient _____	Provider _____
Date _____	Comments _____	Patient _____	Provider _____

**Authorization & Release**

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

**Annual Information Update:**

Date \_\_\_\_\_ No Changes  or Please update the following information \_\_\_\_\_  
Date \_\_\_\_\_ No Changes  or Please update the following information \_\_\_\_\_  
Date \_\_\_\_\_ No Changes  or Please update the following information \_\_\_\_\_