Name: Preferred Name: Date:

Birthday: Age: Sex: M F

Address: Postal Code:

Home Phone #: Health Care #:

Previous Dentist: Last Visit:

Who can we thank for referring you?_____

Parental and Insurance Info

Mom's Name:_____ Birthday:_____

Address If Different:_____

Email Address:_____ _____

Employer:_____ Dental Insurance: Y N

Ins. Provider:_____ Group #:_____ I.D #_____

Dad's Name:_____ Birthday:_____

Address If Different:_____

Email Address:_____ _____

Employer:_____ Dental Insurance: Y N

Ins. Provider:_____ Group #:_____ I.D #_____

Medical History

1. Has your child had a check-up in the last year? Y N Dr._____

2. Is your child presently taking any Medication? Y N Please list:_____

3. Has your child ever taken (Please circle): Penicillin Erythromycin Sulfa Drugs Tetracycline Codeine

4. Are you aware of any allergies to above or any other medication your Physician has advised against giving your child? Please list:_____

5. Any problems healing? **Y N** Fainting Spells? **Y N** Ever been Hospitalized? **Y N** Why?_____

6. Does your Child have Diabetes or require special care due to a medical condition? **Y N**

7. Has your child ever been treated for, or had any indication of: (Please circle)

Heart Ailment/Murmur	*Asthma*	*Nervous Problems*	*Hepatitis A or B*
Heart Surgery	*Respiratory Disease*	*ADD/ADHD*	*Any Blood Disease*
Arthritis	*Chronic Allergies*	*Kidney Problem*	*Epilepsy*
Cancer	*Sinus Problems*	*Liver Problem*	*Stomach or Intestinal Problems*

Any other conditions not listed?

Explain:_____

Dental History

Last complete Dental Exam?_____ Were X-rays taken **Y N**

Has your child ever had their teeth Cleaned or Polished? **Y N**

Has your child ever had Freezing? **Y N** Were there any complications? **Y N**
Explain:_____

Do you feel your child's daily dental care is adequate **Y N**
Explain:_____

How many times per week do you supervise your child's brushing? _____
_____

Does your child suck his/her thumbs or fingers? **Y N** If yes how often:_____

Has your child ever had a bad experience at the dentist? **Y N** If yes explain:_____

How comfortable would you say your child is with today's visit? 1-apprehensive 10-Excited
_____

Do you have any concerns with your child's teeth?
_____

Is your child experiencing any discomfort or pain in his/her teeth?
Explain:_____

Do you have any concerns not covered on this form?_____

Permission to Treat

This is to certify that I, the undersigned, as parent or guardian of the above mentioned child, consent to the performance of any dental and oral surgery procedures agreed to be necessary or advisable. Including the use of local anesthetic as needed. I will assume full responsibility for the fees associated with these procedures. I authorize the release to my insurance company and/or plan administrator any information contained in manual or electronic claims.

Date;_____ Signature of parent or guardian:_____

Appointment Policy:

We would like to ask for your help in providing a minimum of ***TWO BUSINESS DAYS NOTICE***
if for any reason you will be unable to keep a scheduled appointment.
This consideration will allow us to accommodate those patients that may be waiting for an appointment.
If you are unable to provide notice, there will be a $75.00 short notice cancellation fee.
For your convenience, we will continue to call, text, or email you (2 weeks and 2 days) *prior to your appointment to remind you of your visit.*

I have read & understand the above policy. Date:_____ Signature:_____

Signature of Doctor: _____ Date _____