CHILD PATIENT INFORMATION

PLEASE USE PEN

NAME YOU PREFER ____________________

NAME ______________________________ ❑ MALE ❑ FEMALE

MAILING ADDRESS ______________________________
APT # CITY STATE ZIP

STREET ADDRESS (IF DIFFERENT) ______________________________

BIRTH DATE ____________ (MONTH / DAY / YEAR) TELEPHONE (____) ____________ (HOME #) (____) ____________ (WORK #)

CELLULAR OR PAGER (____) ____________ PERSONAL FAX (____) ____________ SS# ____________

SCHOOL ATTENDING ______________________________ E-MAIL ____________

Other family members treated in our office ______________________________

Whom may we thank for referring you to our office? ______________________________ ❑ No Referral

FAMILY INFORMATION

Child lives with: ❑ Mom only ❑ Father only ❑ Shared Custody ❑ Both parents

FATHER

LAST FIRST M

STREET CITY STATE ZIP

(____) ____________ HOME TELEPHONE # (____) ____________ WORK TELEPHONE #

BIRTHDATE (MONTH/DAY/YEAR) SS #

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

MOTHER

LAST FIRST M

STREET CITY STATE ZIP

(____) ____________ HOME TELEPHONE # (____) ____________ WORK TELEPHONE #

BIRTHDATE (MONTH/DAY/YEAR) SS #

EMPLOYER

DENTAL INSURANCE CO. SUBSCRIBER # GROUP #

ALTERNATE CONTACT

Someone not living at your residence

Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Telephone # (____) ______________________________

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 understand 24 hours notice is expected if I need to cancel an appointment, or there may be a $50 fee assessed. I hereby authorize the Dental Office to administer such medications and perform such diagnostic 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. It is my responsibility to notify your office of future changes. I grant the right to the dentist to release my child's dental/ medical histories and other information about my child's dental treatment to third party payers and/or other health professionals.

x ______________________________
❑ Father ❑ Mother ❑ Guardian

____
Date State Driver's License #

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

❑ Guardian ❑ Father Mother

METHOD OF PAYMENT

We file dental insurance as a courtesy to established patients. You must pay the estimated non-covered portion at the time of treatment. It is not our philosophy to allow insurance companies to dictate your child's dental care.

We do not bill for services

Payment in full is due at each appointment. We accept VISA, MasterCard, Discover and American Express for your convenience. We participate in CareCredit financing. If your driver's license number is on file here, we will gladly accept a personal check. Returned checks are subject to $25.00 NSF fee.

FINANCIAL REQUIREMENTS

I have received, read and understand the office financial requirements.

Signature ______________________________

PARENT MUST REMAIN IN THE RECEPTION AREA WHILE CHILDREN ARE BEING TREATED.
YOUR CHILD DESERVES OUR UNDIVIDED ATTENTION. WE WILL COME GET YOU IF WE NEED YOU.

MEDICAL HISTORY

Medical Doctor ____
FIRST & LAST NAME   CITY

CIRCLE YES OR NO FOR EACH ITEM. HAVE YOU EVER HAD:

Excessive Bleeding	No	Yes	Crohn's Disease	No	Yes	Latex Sensitivity	No	Yes
Hepatitis	No	Yes	Arthritis	No	Yes	Cancer	No	Yes
Diabetes	No	Yes	Angina	No	Yes	If yes, what type? ______		
Respiratory Disease	No	Yes	If yes, do you have medication with you? ______			Positive TB Test	No	Yes
If yes, what type? ______			Pacemaker	No	Yes	HIV Positive	No	Yes
Asthma	No	Yes	Stroke	No	Yes	Chemotherapy	No	Yes
High Blood Pressure	No	Yes	Fainting Spells	No	Yes	Radiation Therapy	No	Yes
TMJ	No	Yes	Seizures	No	Yes	Mitral Valve Prolapse	No	Yes
Sinus Problems	No	Yes	Dry Mouth	No	Yes	Rheumatic Fever	No	Yes
Wounds Heal Slowly	No	Yes	Blood Transfusion	No	Yes	Heart Murmur	No	Yes
Are You Pregnant	No	Yes	Thyroid Problems	No	Yes	If yes, does your doctor		
Hard of Hearing	No	Yes	Heart Disease	No	Yes	recommend premedication? ______		
Mouth Ulcers	No	Yes	Fever Blisters	No	Yes	Metal pins, plates, etc.	No	Yes
ADD or ADHD	No	Yes	Reflux	No	Yes	Take blood thinners	No	Yes

CIRCLE IF YOU ARE ALLERGIC TO: Codeine Penicillin Erythromycin Tetracycline Motrin
Other ______________________ No Known Allergies

List major operations ______________________ None ______

List all medicines, herbs or supplements you take daily ______________________ None ______

Are you being treated for any medical problems not listed? ______________________ No ______

Date ______________ **INITIAL CHARTING**

Tooth #	Existing Restoration
1	
2	
3	
4 A	
5 B	
6 C	
7 D	
8 E	
9 F	
10 G	
11 H	
12 I	
13 J	
14	
15	
16	
17	
18	
19	
20 K	
21 L	
22 M	
23 N	
24 M	
25 P	
26 Q	
27 R	
28 S	
29 T	
30	
31	
32	

H_2O Analysis ______________ Results ______________

DENTAL HISTORY **Circle Yes or No**

Areas that catch food	Yes	No
Mouth odor	Yes	No
Bad taste in mouth	Yes	No
Growths in mouth	Yes	No
Tooth injuries	Yes	No
Popping or pain in jaw joints	Yes	No
Loose permanent teeth	Yes	No
Do you crunch ice	Yes	No
Do you chew gum daily	Yes	No
Eat a lot of sweets	Yes	No
Do you smoke	Yes	No
Do you use smokeless tobacco	Yes	No
Brand: ______________		
Nail biting	Yes	No
Grind teeth	Yes	No
Clench teeth	Yes	No
Bleeding gums	Yes	No
Does your home have well water	Yes	No
Do you floss daily	Yes	No
Do you always use a soft toothbrush	Yes	No
Do you use an electronic toothbrush	Yes	No
Sippy Cup	Yes	No

Thumb sucking until age ______________

Pacifier until age ______________

Bad dental experiences

Explain ______________________

Are you in discomfort now Yes No

What brand of tooth paste do you use ______________

Do you swallow the toothpaste Yes No

Time since last dental cleaning ______________

Reaction to having dental work done ______________

What would you like us to do for you? ______________

Why did you change dentists? ______________

Should we request Xrays? Yes No

Previous dentist's name ______________

Daily Consumption of Milk Soda Tea Bottled Water Other