CHILD PATIENT INFORMATION

PLEASE USE PEN

NAME YOU PREFER _____

❑ MALE ❑ FEMALE

NAME _____
FIRST MIDDLE INITIAL LAST

MAILING ADDRESS _____
APT # CITY STATE ZIP

STREET ADDRESS (IF DIFFERENT) _____

BIRTH DATE _____ SS# _____ TELEPHONE (_____) _____
MONTH / DAY / YEAR HOME #

WORK (_____) _____ CELL (_____) _____ EMAIL _____

Do you want appointments confirmed by text message? ❑ YES ❑ NO Preferred method of contact: _____

Other family members treated in our office: _____

How did you hear about our office? _____

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

MOTHER

_____
LAST FIRST M

_____
STREET CITY STATE ZIP

(_____) _____ (_____) _____
HOME TELEPHONE # WORK TELEPHONE #

_____
BIRTHDATE (MONTH/DAY/YEAR) SS #

_____
EMPLOYER

EMERGENCY CONTACT

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 required if I need to cancel an appointment, in order to avoid a $25 late cancellation fee. There will be a charge of $50 if I simply do not show up for an appointment. 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 _____

PARENTS PLEASE 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 **(PLEASE DO NOT MAKE ONE LARGE CIRCLE)** HAVE YOU EVER HAD:

Are you pregnant	No	Yes	Congenital Heart Defect	No	Yes	Cancer	No	Yes
Respiratory Disease	No	Yes	Repair of Heart Defect	No	Yes	If yes, what type? _____		
If yes, what type? _____			Crohn's Disease	No	Yes	Chemotherapy	No	Yes
Asthma	No	Yes	Previous Bacterial			Radiation Therapy	No	Yes
Hepatitis	No	Yes	Endocarditis	No	Yes	Family History of		
Positive TB Test	No	Yes	Arthritis	No	Yes	Head or Neck Cancer	No	Yes
HIV Positive	No	Yes	Hard of Hearing	No	Yes	Latex Sensitivity	No	Yes
Mental Handicap	No	Yes	Fainting Spells	No	Yes	Metal Sensitivity	No	Yes
Diabetes	No	Yes	Seizures	No	Yes	Warts on Fingers	No	Yes
High Blood Pressure	No	Yes	If yes, date? _____			ADD or ADHD	No	Yes
Angina	No	Yes	Thyroid Problems	No	Yes	Eating Disorder	No	Yes
If yes, do you carry meds with you? _____			Blood Transfusion	No	Yes	Reflux	No	Yes
Pacemaker	No	Yes	Organ Transplant	No	Yes	TMJ	No	Yes
Stroke	No	Yes	Pin or Screw in a Joint	No	Yes	Dry Mouth	No	Yes
Heart Disease	No	Yes	Joint Replacement	No	Yes	Sinus Problems	No	Yes
Heart Problems	No	Yes	Excessive Bleeding	No	Yes	Fever Blisters	No	Yes
Mitral Valve Prolapse	No	Yes	Take Blood Thinners	No	Yes	Mouth Ulcers	No	Yes
Speech Therapy	No	Yes	Wounds Heal Slowly	No	Yes	Popping in Jaw Joints	No	Yes
Orthodontic Treatment	No	Yes	Currently Have a Shunt	No	Yes	Pain in Jaw Joints	No	Yes

CIRCLE IF YOU ARE ALLERGIC TO: Codeine Penicillin Augmentin Tetracycline Motrin
Cleocin Ceftin Clindamycin Other _____ No Known Allergies

CIRCLE IF YOU ARE ALLERGIC TO: Kiwi Avocados Bananas Chestnuts None

List any operations _____

List all medicines you take daily _____

Do you take garlic, gingko, ginseng, ginger, fish oil or flax seed oil? No Yes If yes, which one(s)? _____

Are you being treated for any medical problems not listed? _____

Are you up to date on all immunizations? No Yes

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 O	
25 P	
26 Q	
27 R	
28 S	
29 T	
30	
31	
32	

H_2O Analysis _____ Results _____

DENTAL HISTORY **Circle Yes or No**

Previous gum treatment	Yes	No
Mouth odor	Yes	No
Bad taste in mouth	Yes	No
Are you a mouth breather	Yes	No
Growths in mouth	Yes	No
Tooth injuries	Yes	No
If yes, describe _____		
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 (other than at meals)	Yes	No
Thumb sucking until age _____		
Pacifier until age _____		
Bad dental experiences	Yes	No
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 _____		

Frequent use of: Milk Sports/Energy Drinks Soda Tea
Bottled Water Nursery Water Other None

PROGRESS NOTES

DATE	TX'D BY	TOOTH-#	TREATMENT	RTC

PROGRESS NOTES

DATE	TX'D BY	TOOTH-#	TREATMENT	RTC