Children's Dental Office

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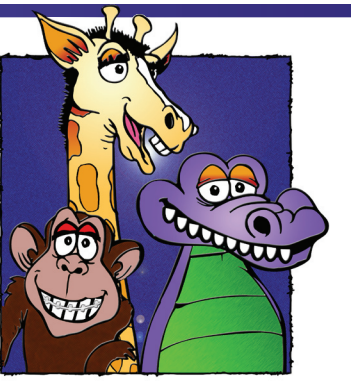

WELCOME

PATIENT INFORMATION

Date of Birth_____ Sex ☐ M ☐ F Age _____ Date _____

Name of Minor/Child _____
Last Name First Name Middle Initial

Nickname_____ Hobbies_____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

E-Mail _____ May we send you appointment reminders by e-mail? ☐ Yes ☐ No

Person financially responsible _____ Contact Phone (_____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____
Address (if different from patient's)

_____

Home Phone (_____)_____ Work Phone (____)_____
(if different from above) (if different from above)

Employer _____

Soc. Sec. #_____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (_____)_____

Address _____

Group #_____ ID # _____

Mother's/Guardian's Name _____
Address (if different from patient's)

_____

Home Phone (____)_____ Work Phone (____) _____
(if different from above) (if different from above)

Employer _____

Soc. Sec. #_____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (_____)_____

Address _____

Group # _____ ID # _____

AUTHORIZATION

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. Leizerovich Bar-Zion all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relationship to Patient

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (_____)_____

Date of last physical examination _____ Results _____

Is minor/child under care of physician now?..... ☐ Yes ☐ No Medications, for what conditions _____

Receiving any medication or drugs?..... ☐ Yes ☐ No _____

Ever been hospitalized?..... ☐ Yes ☐ No _____

Ever had surgery?..... ☐ Yes ☐ No Allergies _____

Is there excessive bleeding when cut?..... ☐ Yes ☐ No _____

Has minor/child had any history of or difficulty with any of the following:

ADHD/ADD	☐ Yes ☐ No	Hay Fever/Seasonal Allergies	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Hearing Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Problems/Heart Murmur	☐ Yes ☐ No
Artificial Joints/Heart Valves	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Latex Sensitivity	☐ Yes ☐ No
Bladder Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Mental Retardation	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Psychiatric Care/Counseling	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Sensory Disorder	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Shunts/Prosthesis	☐ Yes ☐ No
Down's Syndrome	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Drug/Alcohol Abuse	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Fainting	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Other _____	
Gastrointestinal Disorders	☐ Yes ☐ No	_____	

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

Does child brush teeth daily?..... ☐ Yes ☐ No Does child use floss every day?..... ☐ Yes ☐ No

Is fluoride taken in any form?..... ☐ Yes ☐ No If yes, what form?_____

Has child complained about dental problems?..... ☐ Yes ☐ No If yes, explain: _____

Any injuries to mouth, teeth, head?..... ☐ Yes ☐ No If yes, explain: _____

Any mouth habits (CIRCLE ONE: thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, other)?..... ☐ Yes ☐ No

Any unhappy dental experiences?..... ☐ Yes ☐ No If yes, explain: _____

Do you have concerns?..... ☐ Yes ☐ No If yes, explain: _____

CONSENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____ and there are no court orders now in effect that
Please Print Name of Minor/Child

prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

_____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient