

PETER M. HECKLER, D.D.S., INC.
NANCY MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Date _____
Child's Name _____
Nickname _____
Date of Birth _____ Age _____ Sex _____
SS# _____ Grade _____
School Attending _____
Hobbies _____
How did you hear about us? _____

PARENT INFORMATION

Father's Name _____
RESIDES WITH CHILD? YES NO
SS# _____ Date of Birth _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Employer _____
Occupation _____
Employer's Address _____
City/State/Zip _____
Driver's License # _____
Mother's Name _____
RESIDES WITH CHILD? YES NO
SS# _____ Date of Birth _____
Address _____
City/State/Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Employer _____
Occupation _____
Employer's Address _____
City/State/Zip _____
Driver's License # _____

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

Late charges: If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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. I understand that payment is due at the time of service unless other arrangements have been made.

X _____
Signature of patient or parent if minor Date

GENERAL INFORMATION

Has your family been here before? Yes No
Name and Ages of Brothers and Sisters _____

DENTAL INSURANCE INFORMATION

Name of Insured _____
Relationship to patient _____
Insured's birth date _____ SS# _____
Employer _____ Date Employed _____
Employer Address _____
Insurance Company _____
Group # _____
Ins. Co. Address _____

ADDITIONAL INSURANCE

Name of Insured _____
Relationship to patient _____
Insured's birth date _____ SS# _____
Employer _____
Employer Address _____
Insurance Company _____
Group # _____
Ins. Co. Address _____

RESPONSIBLE PARTY

Who is responsible for the account?
Name _____
Birth date _____ SS# _____
Relationship to patient _____
Address _____
City/State/Zip _____
Employer _____
Employer Address _____
Work Phone _____ Home Phone _____

HEALTH HISTORY

Child's Physician _____ Phone _____

	Yes	No
Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list _____		
Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____		
Is the child allergic to anything else such as certain drugs? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
How would you describe the child's eating habits? _____		
Has the child ever had a serious illness? If yes, when _____ please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever received general anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any speech difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child physically, mentally, or emotionally impaired?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child experience excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problem with dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had dental radiographs (x-rays) exposed?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever suffered any injuries to the mouth, head or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problems with the eruption or shedding of teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
What type of water does your child drink? _____ City water _____ Well water _____ Bottled water _____ Filtered water		
Does the child take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride toothpaste used?	<input type="checkbox"/>	<input type="checkbox"/>
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		
Does the child suck his/her thumb, fingers or pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
Does child participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>

Has the child had any history of, or conditions related to, any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy (Teens) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bone/Joints | <input type="checkbox"/> HIV + / AIDS | <input type="checkbox"/> Tobacco / Drug Use |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Others please list _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Liver | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Mononucleosis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | |

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff on the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor _____ Date _____ BP _____

History Review and Significant Findings _____