619 S. Heatherwilde Blvd. • Pflugerville, Texas 78660 • 512-989-6900 • www.drbainpediatricdentist.com

Date_____ SS# _____ Birthdate _____

Name of Minor/ Child_____ Sex □ M □ F Age_____

Nickname_____ Hobbies_____ Cell Phone (___) _____

Home Address_____City_____State_____ Zip_____

School Name_____School Phone_____

Person Financially responsible _____Home Phone (___) _____

*Whom may we thank for referring you? _____

Father's / Guardian's Name_____

Address (if different from patient's) _____

_____

Cell Phone (___)_____ Home/Work Phone (___)_____

Email_____

Employer_____

Soc. Sec. #_____DOB_____

Do you have dental Insurance Coverage for the Minor/ Child? □Yes □ No

Plan Name_____ Phone (___)_____

Address_____

Group # _____ Policy _____

Mother's / Guardian' Name_____

Address (if different from patient's)_____

_____

Cell Phone (___)_____ Home/Work Phone (___)_____

Email _____

Employer_____

Soc. Sec # _____ DOB_____

Do you have Dental Insurance Coverage for the Minor/Child? □Yes □ No

Plan Name_____ Phone (___)_____

Address_____

Group # _____ Policy _____

Is your child eligible for treatment under Medical Assistance □ Yes □ No Child's Medical Assistance I.D. #_____

Date of Last visit to a dentist_____ For What Service?_____

Has child complained about dental problems? □ Yes □ No Is Fluoride taken in any form? □ Yes □ No

Does child brush teeth daily? □ Yes □ No Any injuries to mouth, teeth, head? □ Yes □ No
Does child use floss everyday? □ Yes □ No Any unhappy dental Experiences? □ Yes □ No
Any mouth habits- thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? □ Yes □ No

CHILDS NAME_____

Minor/Child's Physician_____ City/ State_____ Phone (____)_____

Date of Last physical examination_____ Results_____

Is Minor/child under care of physician now? □ Yes □ No Medications_____

Receiving any medications 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? If yes, please check.

□ A.I.D. S. / H.I.V □ Cerebral Palsy □ Epilepsy □ Kidney Disease □ Rheumatic Fever

□ Anemia □ Chicken Pox □ Fainting □ Liver Disease □ Sinus Problems

□ Asthma □ Latex Allergy □ Convulsions □ Hearing Problems □ Measles □ Thyroid Disease

□ Bladder Problems □ Diabetes □ Heart Problems □ Mononucleosis □ Tuberculosis

□ Cancer □ Drug/ Alcohol Abuse □ Hepatitis □ Mumps □ Special Needs Other: _____

In the Event of an emergency, whom should we contact?

Name_____ Relationship _____ Phone (___) _____

Name_____ Relationship _____ Phone (___) _____

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 _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do herby 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.
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. _____ 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. This consent will end three years from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

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