WELCOME!

Thank you for your visit today! We are pleased to welcome you and your child to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask – we will be glad to help. We look forward to working with you to maintain your child's dental health!

PATIENT INFORMATION

Date _____ Home phone _____

Child's Name _____ Nickname _____

Sex ☐ Male ☐ Female Age _____ Birthday _____ Hobbies _____

Home address _____

Mailing address _____

Person financially responsible _____ Home phone _____ Work phone _____

Whom may we call in case of an emergency? _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Date of last dental visit _____ For what service? _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, or head?	☐	☐
Does child floss teeth daily?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? _____

_____

MEDICAL HISTORY

Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

_____

	Yes	No
Is child under the care of a physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

Allergies _____

_____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Kidney Disease
☐ Cancer	☐ Drug/Alcohol abuse	☐ Hepatitis	☐ Mumps	☐ Other

Primary Insurance

Who is responsible for this account? _____

Name _____

Relation to patient _____ Birthdate _____ Social Security # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____

Employed by _____ Occupation _____

Business address _____ Work phone _____

Insurance company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

Secondary Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber name _____ Relation to patient _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____

Subscriber employed by _____ Work phone _____

Insurance company _____ Social Security # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered by this plan _____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

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.

Signature _____ Date _____

Payment is due in full at time of treatment.