

IF THIS APPOINTMENT IS FOR YOU

DATE			
NAME			
SPOUSE			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL NO.		
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL	GRADE		
SOCIAL SECURITY NO.			

PRIMARY CARRIER

DENTAL INSURANCE COMPANY	
GROUP NO.	
EMPLOYER	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

SECONDARY CARRIER

DENTAL INSURANCE COMPANY	
GROUP NO.	
EMPLOYER	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION

NAME OF PERSON FINANCIALLY RESPONSIBLE		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
EMAIL ADDRESS:		
OCCUPATION		
EMPLOYER		
BUSINESS PHONE NO.		

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP	
REFERRED TO US BY		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP

CONSENT

I hereby authorize doctor or designated staff to take x-rays, study model, photographs, and any other diagnostic aids deemed appropriate by a doctor to make a thorough diagnosis of dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1½% finance charge (18% APR) may be added to my account.

Patient or Responsible Party _____ Date _____

Your Child's Medical History

Your Child's Name _____ Nickname _____ Date _____

Birth Date _____ Patient Acct. No. _____ Medical Alert _____

Your Child's Physician: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Is your child under the care of a physician? Yes No

If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter) Yes No

If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment? Yes No

Any history of Heart Murmur, Rheumatic Fever, Artificial Joints or Mitral Valve Prolapse?..... Yes No

Does your child have any allergic (or adverse) reaction to any medication or other substance? Yes No

If yes, please list _____

Are your child's immunizations current? Yes No

List Any Hospitalizations, Surgeries, Serious Illnesses

When?

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

- | | | |
|---|--|--|
| AIDS/HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital heart disease . <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung problem <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles/Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous disorders <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Behavioral/Learning problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric/Psychological ... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic/Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Injury <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart condition <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle cell anemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A B C (circle).. <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach problem <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cerebral palsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Liver problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Other? Yes No Please specify _____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ Date _____

Dentist's Review

Dentist's Signature _____ Date _____

Your Child's Dental History and Habits

Your Child's Name _____ Nickname _____ Date _____

Welcome! So that we may provide your child with the best possible care, please complete both sides of this dental/ medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions

What is the reason for your visit today? _____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? Yes No

Is your child's water fluoridated? Yes No Does your child take fluoride supplements? Yes No

Does your child have any dental problems now? Yes No If yes, please describe _____

How do you think your child will do? Good Fair Poor

Has your child had difficulty with previous dental visits? Yes No If yes, please describe _____

Has your child complained about dental problems? Yes No If yes, please describe _____

Has your child ever worn orthodontic appliances? Yes No If yes, please describe _____

Are any of your child's teeth sensitive to:

Hot or cold? Yes No Sweets? Yes No Biting or Chewing? Yes No

Does your child engage in:

Sucking thumb or fingers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing or biting fingernails? <input type="checkbox"/> Yes <input type="checkbox"/> No
Biting or sucking lips or cheeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing hard objects (e.g., pencils)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing bottle or pacifier habits? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do your child's gums bleed or hurt? Yes No

Does your child have any pain or tenderness in the jaw joint, ear, side of face? Yes No

Do you have any special concerns about your child's dental health? Yes No If yes, please describe _____

