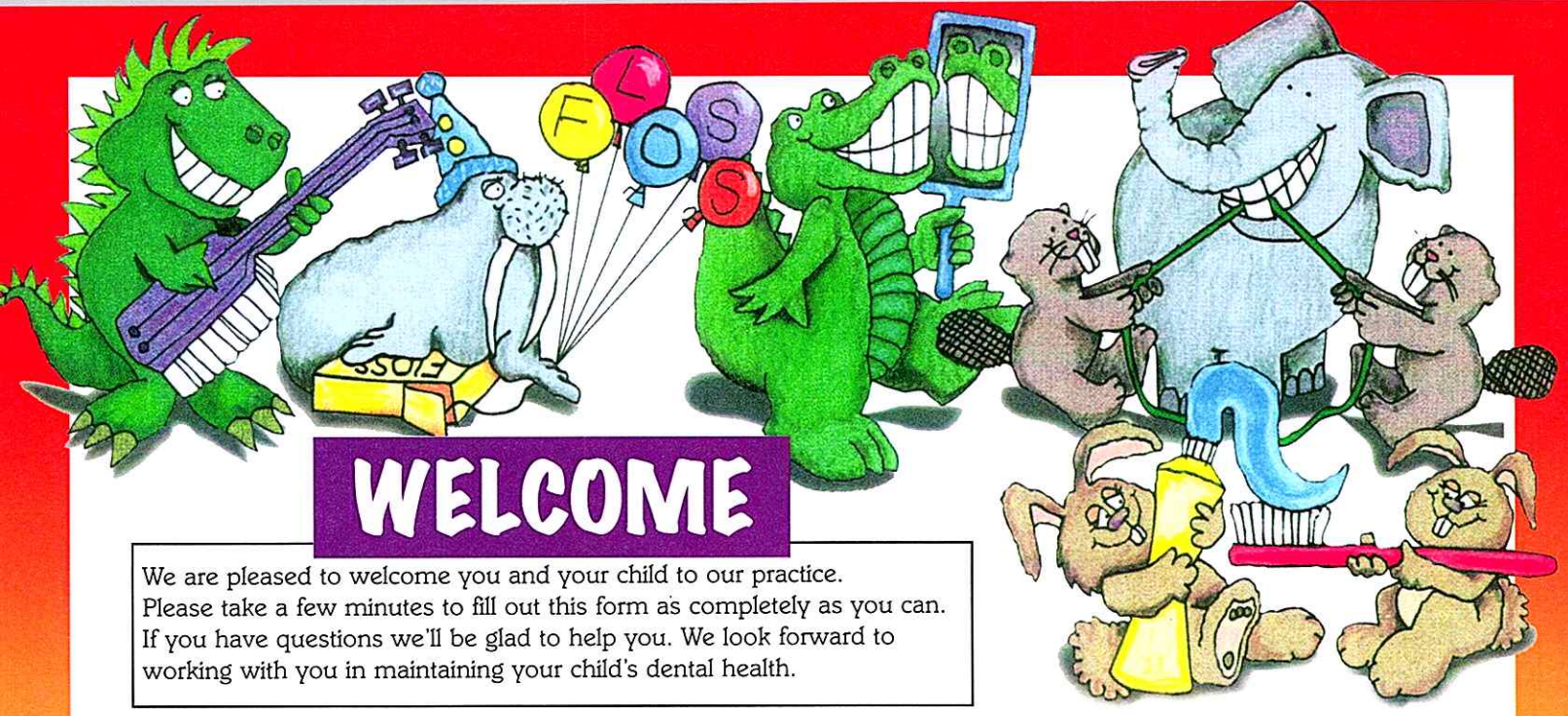


WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home (____) _____ Work (____) _____

Whom may we thank for referring you? _____

PARENT INFORMATION

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

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

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

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

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

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

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for 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. # _____

DENTAL HISTORY

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

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

Please Complete Both Sides

MEDICAL HISTORY

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

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ ADD/ADHD	☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Rheumatic Fever
☐ A.I.D.S./H.I.V.	☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Seizures
☐ Anemia	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems
☐ Asthma	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Thyroid Disease
☐ Autism	☐ Developmental Delays	☐ Hearing Problems	☐ Mononucleosis	☐ Other

EMERGENCY CONTACT

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

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATION

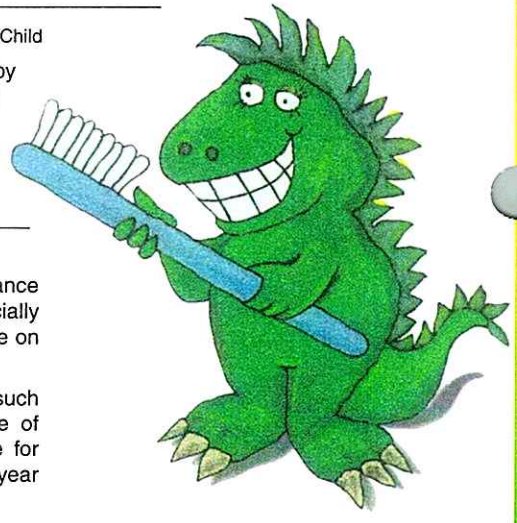
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

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 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.



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 when the current treatment plan is completed or one year 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