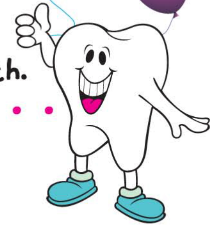
W.E.L.C.O.M.E.

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 # ______ BIRTH DATE ______

NAME OF MINOR / CHILD ______ SEX ☐ M ☐ F AGE ______

NICKNAME ______ HOBBIES ______ CELL PHONE ( ) ______

HOME ADDRESS ______
STREET ______ CITY ______ STATE ______ ZIP ______

MAILING ADDRESS ______
STREET ______ CITY ______ STATE ______ ZIP ______

SCHOOL NAME ______ SCHOOL PHONE ( ) ______

PERSON FINANCIALLY RESPONSIBLE ______ HOME PHONE ( ) ______ WORK PHONE ( ) ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

INSURANCE

FATHER'S / GUARDIAN'S NAME ______

ADDRESS (if different from patient's) ______

HOME PH ( ) ______ WORK PH ( ) ______
(if different fromabove) (if different from above)

EMAIL ______

EMPLOYER ______

SS # ______ BIRTH DATE ______

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 PH ( ) ______ WORK PH ( ) ______
(if different fromabove) (if different from above)

EMAIL ______

EMPLOYER ______

SS # ______ BIRTH DATE ______

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 ID # ______

DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST ______

Has child complained about dental problems? ☐ YES ☐ NO

Does child brush teeth daily? ☐ YES ☐ NO

Does child use floss everyday? ☐ YES ☐ NO

FOR WHAT SERVICE? ______

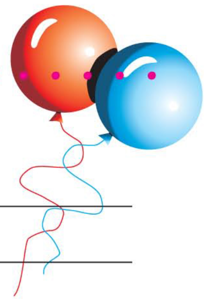
Is fluoride taken in any form? ☐ YES ☐ NO

Any injuries to mouth, teeth, head? ☐ YES ☐ NO

Any unhappy dental experiences? ☐ YES ☐ NO

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ YES ☐ NO

- OVER -



MEDICAL HISTORY

MINOR / CHILD'S PHYSICIAN ____ CITY / STATE ____ PHONE ( ) ____

DATE OF LAST PHYSICAL EXAMINATION ____ RESULTS ____

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

MEDICATIONS ____

ALLERGIES ____

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

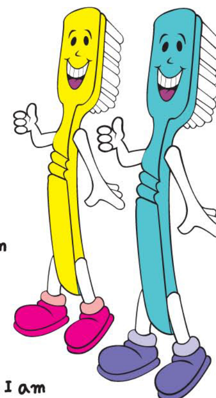
☐ AIDS / HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐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

EMERGENCY CONTACT

NAME ____ RELATIONSHIP ____ PHONE ( ) ____

NAME ____ RELATIONSHIP ____ PHONE ( ) ____

AUTHORIZATIONS



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 ____ 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.

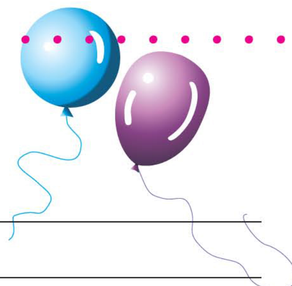
INSURANCE ASSIGNMENT AND RELEASE

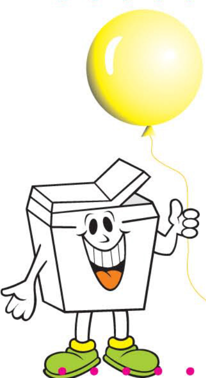
I certify that my dependent(s) is covered by insurance with ____ and assign directly to

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





UPDATE (to be filled in at future appointments)

Has there been any change in patient's health since last dental appointment? ☐ YES ☐ NO

If yes, please describe ____

Is patient taking any new medications? ☐ YES ☐ NO If yes, please list ____

DATE ____ PARENT / GUARDIAN SIGNATURE ____

DATE ____ DENTIST SIGNATURE ____