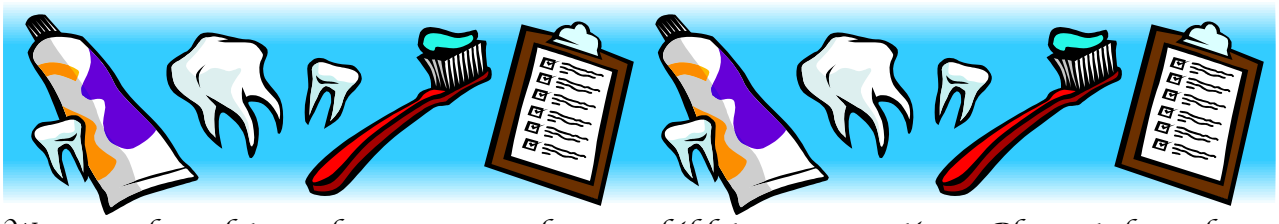

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you and your child.

Patient Information

Child's Name:_____ SSN#:_____
Last Name First Name Initial

Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Sex: ☐ M ☐ F Age:_____ Birthdate:_____ School:_____

Grade:_____ Hobbies/Sports:_____

Notify in case of emergency:_____Hm.#_____Wk. #:_____

Dental History

Date of last dental visit:_____

How often does your child floss?_____

Have you ever been told you needed antibiotic pre-medication for dental treatment? YES NO

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth
☐ Lip or Cheek Biting ☐ Jaw Pain ☐ Sensitive Teeth
☐ Orthodontic treatment ☐ Tobacco

Medical History

Have you been under the care of a physician within the past 2 years? If so what condition(s) is being treated?_____

Please list all medications you are currently taking, including oral contraceptives?

_____

Please check all that apply to your child:

☐ Allergies ☐ Epilepsy ☐ Scarlet Fever
☐ Anemia ☐ HIV/AIDS ☐ Tonsilitis
☐ Asthma ☐ Heart Murmur ☐ Tuberculosis
☐ Cancer ☐ Hepatitis-type_____ ☐ Other_____
☐ Diabetes ☐ Rheumatic Fever

Allergies – are you allergic to or have you had a reaction to :

Yes	No		Yes	No	
☐	☐	Local Anesthetic (Novocain)	☐	☐	Latex
☐	☐	Sulfa	☐	☐	Penicillin or other antibiotics_____
☐	☐	Aspirin	☐	☐	Other (specify)_____

Mother

Name: _____ ☐ Stepmother
Last Name First Name Initial

Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Work Number:_____ SSN:_____

Employer:_____ Occupation:_____

Father

Name: _____ ☐ Stepfather
Last Name First Name Initial

Address:_____ City:_____ State:_____ Zip:_____

Home Number:_____ Work Number:_____ SSN:_____

Employer:_____ Occupation:_____

Primary Insurance

Person Responsible for Account:_____
Last Name First Name Initial

Relation to Child:_____ Birthdate:_____ SSN:_____

Person Responsible Employed by:_____ Occupation:_____

Insurance Company:_____ Phone:_____

Group#:_____ Name of other dependents under this plan:_____

Additional Insurance

Is child covered by additional insurance? ☐ Yes ☐ No Subscriber Name:_____

Subscriber SSN:_____ Relation to Child:_____ Birthdate:_____

Person Responsible Employed by:_____ Occupation:_____

Insurance Company:_____ Phone:_____

Group#:_____ Name of other dependents under this plan:_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group. 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 for my dependents.

_____

Signature of parent Date