Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Patient ID # ___________

YOUR CHILD

Today's Date ___________

Child's Name______________________________ Nickname ______________

Sex Male Female Birthdate ____________ Age ____________ Social Security # ______________

School ______________________________ Grade______________

Child's Home Address ______________________________

City, State, Zip ______________________________

PARENT'S MARITAL STATUS

Single Divorced
Married Widowed

Separated

Referred to our office by:

____

E-MAIL ADDRESS:

____

MOTHER

STEPMOTHER
GUARDIAN

Name ______________________________

Home Phone ____________ Work Phone ____________

Employer ______________________________

Occupation ______________________________

Social Security #______________________________

DL # ______________________________

FATHER

STEPFATHER
GUARDIAN

Name ______________________________

Home Phone ____________ Work Phone ____________

Employer ______________________________

Occupation ______________________________

Social Security #______________________________

DL # ______________________________

RESPONSIBLE PARTY

Name ______________________________ Relationship ______________

Address ______________________________

City, State, Zip ______________________________

Social Security #______________________________ DL # ______________

In case of an emregency, whom should we contact?

Name ______________ Phone______________

Who is responsible for making appointments?

Name ______________________________

Home Phone ______________ Work Phone ______________ Ext. ______________

Best time to call ______________ Time ______________ Days ______________

PRIMARY DENTAL INSURANCE

Insured's Name ______________________________ Relationship______________________________

Birthdate______________________________ Social Security # ______________________________

Employer______________________________ Date Employed ______________________________

Occupation ____

Insurance Carrier____

Group # ______________________________ Employer # ______________________________

Ins. Co. Address______________________________ City, State, Zip ______________________________

Deductible ______________________________ Amount already used ______________________________

Max. annual benefit ____

Orthodontic Coverage ☐ Yes ☐ No

ADDITIONAL INSURANCE

Insured's Name ______________________________ Relationship______________________________

Birthdate______________________________ Social Security # ______________________________

Employer______________________________ Date Employed ______________________________

Occupation ____

Insurance Carrier____

Group # ______________________________ Employer # ______________________________

Ins. Co. Address______________________________ City, State, Zip ______________________________

Deductible ______________________________ Amount already used ______________________________

Max. annual benefit ____

Orthodontic Coverage ☐ Yes ☐ No

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_______ Cash

_______ Personal Check

_______ Credit Card _______ Visa _______ MC

_______ I wish to discuss the dental office's policy.

LATE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then Unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION AND RELEASE

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 payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

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 or my dependents.

X ____

Signature of patient or parent if minor Date

CONFIDENTIAL HEALTH HISTORY

Date ______________ Child's Name ________________________ Patient ID # ______________
Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the Following questions completely.

Child's Habits

How often does your child brush? ____

How often does your child floss? ____

Does your child:

Suck thumb/finger	Yes	No
Suck/Bite lips	Yes	No
Bite/Chew nails	Yes	No
Chew hard objects (pencils, etc.)	Yes	No
Grind teeth	Yes	No
Clench jaws	Yes	No

Date of last dental visit ___________________________

Previous dentist _________________________________

Child's physician ________________________________

Phone# _______________________________________

Child's Birthdate_________________________________

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

Health History

Has your child had difficulty with previous dental visits?____

Has your child ever had any of the following:

Asthma	Yes	No	Handicaps/Disabilities	Yes	No
Cancer	Yes	No	Tuberculosis	Yes	No
Hepatitis	Yes	No	Diabetes	Yes	No
HIV / AIDS	Yes	No	Rheumatic Fever	Yes	No
Hemophilia	Yes	No	Congenital Heart Defect	Yes	No
Abnormal Bleeding	Yes	No	Heart Murmur	Yes	No
Allergies	Yes	No	Convulsions / Epilepsy	Yes	No

Please explain any medical condition that your child has ____

____

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing Incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I also authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of parent of guardian Date

Dentist's Review

____

____

____

Date ____

Signed Dr. ____

Health History Update

Date ______________________ Comments ______________________________

____

Signature ____

Date ______________________ Comments ______________________________

____

Signature ____