



Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs, please fill out this form completely.

PATIENT INFORMATION

Date _____ Name _____ Nickname _____

Sex M F Age _____ Birthdate _____ Home Phone() _____

Mailing Address _____
Street City State Zip

Mother _____ Work Ph (____) _____ Ext _____ Cell (____) _____

Father _____ Work Ph (____) _____ Ext _____ Cell (____) _____

Guardian _____ Relationship _____ Phone _____

Names and ages of siblings: _____

How did you hear about us? _____

Reason for today's appointment? _____

PERSON BRINGING CHILD TO THE APPOINTMENT

Name _____ Relationship to patient _____

Birthdate _____ SS# _____ - _____ Driver's License # _____

Address (if different from patient) _____ Phone _____

Occupation _____ E-mail address _____

INSURANCE INFORMATION

Primary Insurance Plan: _____ Secondary insurance? Yes No

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or 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.

**Payment is due in full at time of treatment unless
prior arrangements have been approved.**

Signature _____ Print Name _____ Date _____

If you have any questions or need assistance, please ask us – we are always happy to help.

MEDICAL HISTORY

Physician's Name _____ City/State _____ Phone _____

Date of last appointment _____ Reason? _____

	Yes	No	
Is Minor/Child under care of physician now?.....	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
Receiving any medication or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is there excessive bleeding when cut?.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Any congenital disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE check yes or no to all the following conditions:

<input type="checkbox"/> Y <input type="checkbox"/> N Aids/HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Digestive Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Problems
<input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Blood disease	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing impaired	<input type="checkbox"/> Y <input type="checkbox"/> N Special Needs
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Brain Injury	<input type="checkbox"/> Y <input type="checkbox"/> N Autism
<input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N Down's syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N Latex Allergy
<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems	

Please explain any medical conditions: _____

DENTAL HISTORY

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

Previous dentist _____ City/State _____ Phone _____

	Yes	No		Yes	No
Has child complained about dental problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child floss regularly?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Doctor's signature _____ Comments _____

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 exam and X-rays for diagnosis and cleaning.

Signature _____ Print name _____ Relationship _____