

We would like to welcome you and your child to our practice! Our goal is to make every child's visit pleasant and educational.

Our practice is based on preventive care. We strive to teach healthy oral habits that will enable your child to have a beautiful smile that lasts a lifetime.

About Your Child

Name _____ Date of Birth _____
Address _____ Apt# _____
City _____ State _____ Zip _____
Telephone _____ Social Security Number _____
Other family members at this office yes no _____
Referred by _____

About You

Name _____ Check here if address same as above yes
Address _____ Apt# _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell/Pager) _____
Relationship to Child _____

Financial Information

Primary Insurance Carrier

Employed By _____ Dental Ins. Co. _____
Employee _____ Employee Date of Birth _____
Employee SSN _____ Union/Local # _____ Group # _____

Secondary Insurance Carrier

Employed By _____ Dental Ins. Co. _____
Employee _____ Employee Date of Birth _____
Employee SSN _____ Union/Local # _____ Group # _____

Person Responsible for Paying This Account (if different than above) _____
Address _____ Apt# _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell/Pager) _____

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. Therefore, it is your responsibility to know your individual coverage. Failing to do so will result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between the insurance company and your dentist. Payment is required at the time of service; however, if insurance is involved, payment will be expected on the copy. On major work, at least half payment is required at time of service. **If for any reason insurance does not pay in a reasonable time, payment will be expected from the patient.**

Most importantly, we are here to help in any way we can, and look forward to meeting your dental needs. Again, welcome to our practice.

I accept and understand the patient responsibilities outlined above:

Parent or Guardian _____ Date _____

Medical / Dental History

Has your child ever had any of the following medical conditions or problems (please circle all that apply)

Heart Murmur	Heart problems of any kind	Convulsions/Epilepsy	Diabetes
Rheumatic Fever	HIV/AIDS	Hemophilia	Bleeding disorders
Hearing Impairment	Hyperactivity (ADD/ADHD)		

Food Allergies If yes, what type? _____

Cancer If yes, what type? _____
Did he/she receive radiation / chemotherapy? (circle those that apply)

Any operations? _____
Any stays in the hospital? _____

Are there any medical conditions or problems relating to your child that need further explanation?

Physician's name _____ Telephone _____

Approximate date of last visit _____

Please rate your child's mental health Good Fair Poor

Is your child allergic to any medications? yes no

If yes, please list _____

Is your child currently taking any prescription medications? yes no

If yes, please list _____

Does your child need to be premedicated before dental treatment? yes no

Has your child been to the dentist before? yes no

If yes, the approximate date of last visit? _____

Are there any dental problems that you are aware of at present? yes no

If yes, please explain _____

Does your child brush his/her teeth daily? yes no

Please rate your child's oral health. Good Fair Poor

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

Name _____ Relationship _____

Phone _____ Phone #2 _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Parent or Guardian _____ Date _____

Witness _____ Date _____

Doctor _____ Date _____

Medical history updates

Initial/Date _____



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