1 ABOUT YOUR CHILD

Today's Date: ……/……../…….. File #:……

Child's Name:……..

LAST FIRST MI

Child's Nickname:…… ☐ Boy ☐ Girl

Child's Birthdate: ……/……../…….. Age:……..

School: ……Grade..…...

Child's Home Phone #: (……)……..……

Child SS#:……

Child's Address: ……

HOME ADDRESS

……

CITY STATE ZIP

Referred By:

……

(If doctor, please give address & phone number.)

……

2 INSURANCE INFORMATION

Primary Dental Insurance

Co. Name:……..

Address: ……

……

CITY STATE ZIP

Phone #: (……)……

Insured's ID#: ……

Group # (Plan, Local, or Policy #): ……

Insured's Name:……

Relation:……Date of Birth:…./……/…..

Insured's Employer: ...……...

Do either policy cover Orthodontics? ☐ Yes ☐ No

Secondary Dental Insurance

Co. Name: ……

Address: ……

……

CITY STATE ZIP

Phone #: (……)……

Insured's ID#:……

Group # (Plan, Local, or Policy#): ……

Insured's Name:……

Relation:……Date of Birth:…./……/……..

Insured's Employer: ...……...

3 CHILD'S FAMILY INFORMATION

Who is accompanying this child today?

…….. ……

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ☐ Yes ☐ No

How many Brothers/Sisters? …..... Age(s):……..……..

Mother's Name:……..……

☐ STEP MOTHER ☐ GUARDIAN

……

(☐**CHECK IF SAME AS CHILD'S**) HOME ADDRESS CITY STATE ZIP

(……)……..…… (…..…)……..... ……..…..

HOME PHONE # WORK PHONE # EXT.

……. …./……/……. ……

MOTHER'S SOCIAL SECURITY# DATE OF BIRTH MOTHER'S DRIVERS LIC.#

Employer: ...……...How long?.....

……

EMPLYER'S ADDDRESS CITY STATE ZIP

Father's Name:……..……

☐ STEP FATHER ☐ GUARDIAN

……

(☐**CHECK IF SAME AS CHILD'S**) HOME ADDRESS CITY STATE ZIP

(……)……..…… (…..…)……..... ……..…..

HOME PHONE # WORK PHONE # EXT.

……. …./……/……. ……

FATHER'S SOCIAL SECURITY# DATE OF BIRTH FATHER'S DRIVERS LIC.#

Employer: ...……...How long?.....

……

EMPLYER'S ADDDRESS CITY STATE ZIP

4 ACCOUNT INFORMATION

Person ultimately responsible for account

Name:…….. ……..…..

RELATION TO CHILD

Billing Address: ……

……

CITY STATE ZIP

…… ……/……/……. ……

SOCIAL SECURITY# DATE OF BIRTH DRIVERS LIC. #

(……)…… …… (……)……..…..

WORK PHONE # EXT. CELLPHONE #

Payment method: ☐ Cash ☐ Check

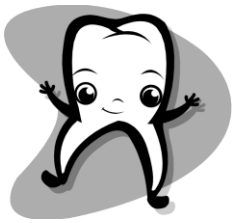
…….. ……/…….

☐ Credit card - Enter card # above (if accepted)

…… I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

Initials

PLEASE CONTINUE ON BACK



5 CHILD'S DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation
Is Child in pain? ☐ No ☐ Yes How Long?……..
Please indicate ☑ any of the following problems:
☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth ☐ Loose tooth
☐ Other: ……..
Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know
Previous Dentist: …… (……)……
Name Phone #
Last Dental exam:……/……/……. Last Dental X-rays:……/……/…….....
Times a day child brush?..... Times a week child floss? ……..
Is the child's water fluoridated? ☐ Yes ☐ No
How would you rate child's smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 CHILD'S MEDICAL HISTORY

Is Child taking any of the following medications? ☐ Pain killers (including aspirin) ☐ Ritalin ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Other(s)…….
Child's Physician: …… (……)……
DOCTOR'S NAME OR CLINIC NAME PHONE #
…….. Last Medical Exam:……/……/…….
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other surgeries or medical conditions child has or ever had:……..
……
Is Child allergic to any of the following? ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Lidocaine)
☐ Aspirin ☐ Food allergies ☐ Others:……
Please rate your general health from 1-10 …… Does Child wear contact lenses? ☐ Yes ☐ No
Has this child ever taken the drug Ritalin? ☐ No ☐ Yes/How long?..... Child's Blood type:……
Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

■ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
■ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature……Date……/……/……
☐ Parent or Guardian ☐ Other

UPDATE
(OFFICE USE)

…… ……/……/……
Initials Date
……
Comments

…… ……/……/……
Initials Date
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Comments

…… ……/……/……
Initials Date
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Comments