Patient Information

Name of Minor/Child _____ Date_____

Nickname_____ Sex ☐ M ☐ F Age_____ Birthday_____

Home Address _____

Person financially responsible_____

Home Phone_____ Work Phone_____ Cell Phone_____

Whom may we thank for referring you? _____

Insurance

Father's/Guardian's Name_____

Address (if different from patients) _____

_____

Home Phone _____ Work Phone_____
(if different from above)

Employer_____

SS#_____ Birthday_____

Do you have dental insurance coverage for minor/child?
_____Yes _____No

Plan Name_____

Phone Number_____

Address _____

_____

Group #_____ Policy #_____

Mother's/Guardian's Name _____

Address (if different from patients) _____

_____

Home Phone _____ Work Phone_____
(if different from above)

Employer_____

SS#_____ Birthday_____

Do you have dental insurance coverage for minor/child?
_____Yes _____No

Plan Name_____

Phone Number_____

Address _____

_____

Group #_____ Policy #_____

Is your child eligible for treatment under Medical Assistance? _____Yes _____No Child's Medical Assistance ID# _____

Dental History

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

Has child complained about dental problems?	YES	NO	Is fluoride taken in any form?	YES	NO
Does child brush teeth daily?	YES	NO	Any injuries to mouth, teeth, head?	YES	NO
Does child use floss everyday?	YES	NO	Any unhappy dental experiences?	YES	NO

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacificer, sleeping with bottle, etc? YES NO

Medical History

Minor/Child's Physician_____ City/State_____ Phone _____

Date of last physical examination_____ Results_____

Is Minor/Child user care of physician now?	YES	NO	Medications _____
Receiving any medication or drugs?	YES	NO	_____
Ever been hospitalized?	YES	NO	_____
Ever had surgery?	YES	NO	Allergies _____
Is there excessive bleeding when cut?	YES	NO	_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK

___AIDS/HIV	___Anemia	___Asthma	___Bladder Problems	___Cancer
___Cerebral Palsy	___Chicken Pox	___Convulsions	___Diabetes	___Drug/ Alcohol Abuse
___Epilepsy	___Fainting	___Hearing Problems	___Heart Problems	___Hepatitis
___Kidney Disease	___Liver Disease	___Measles	___Mononucleosis	___Mumps
___Rheumatic Fever	___Sinus Problems	___Thyroid Disease	___Tuberculosis	___Other

Emergency Contact

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

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Authorization

The information that I have given is correct to the best of my knowledge. I understand 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 authorize the dental staff to perform the necessary dental services for my minor/child.

_____ _____

Signature of Parent/Guardian Date

I certify that my minor/child is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the dentist re release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian Date