PATIENT INFORMATION

(This information is necessary for our files and will be considered CONFIDENTAL)

Name Last First Sex(M/F)

Home Address

City, State, Zip

Home Phone **Cell Phone**

Date of Birth **Marital Status**

Nearest Relative or Friend (Name and Phone)

Other Family Members

Driver's License # **Social Security #**

Employer **Occupation**

Employer's Address

Employer's City, State, Zip

Employer's Phone # **Ext.**

E-Mail Address (To receive Appointment Reminder's)

How do you wish to be addressed?

Whom may we thank for referring you?

RESPONSIBLE PERSON

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

Name of Responsible Party

Date of Birth

Driver's License # **Social Security #**

Relation to Patient (Spouse or Parent)

Employer **Occupation**

Employer 's Address

Employer's City, State, Zip

Employer's Phone # **Ext.**

INSURANCE INFORMATION

PRIMARY INSURANCE

Insured Person's Full Name **Relation to Patient**

Member ID or Social Security # **Date of Birth**

Name of Insurance Company

Insurance Company Phone # **Group/ Local Number**

SECONDARY INSURANCE

Insured Person's Full Name **Relation to Patient**

Member ID or Social Security # **Date of Birth**

Name of Insurance Company

Insurance Company Phone # **Group/Local Number**

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand the use of anesthetic agents embodies a certain risk. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental Insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental Insurance carrier. I further understand that a 1.5 % finance charge (18% annually) will be added to any balance over 90 days. I attest to the accuracy of the information on this page.

Patient's or Responsible Person's Signature **Date**

CHILD MEDICAL HISTORY

PATIENT NAME_____ **BIRTHDATE**_____

PARENT/GUARDIAN NAME_____
Father's Name **Mother's Name**

1. Physician/Pediatrician_____
Name Address Phone
2. If child currently receiving medical care, what for?_____
3. Date of last physical exam?_____
4. List Medications child is currently taking?_____
5. List Child's Drugs/Antibiotics allergic/sensitive to_____
6. What other allergies does child have?_____
7. What if any serious illnesses or surgeries has child had?_____
8. Has your child ever had:

			COMMENTS
Anemia…….	YES	NO	
Asthma…….	YES	NO	
Bleeding Tendency…….	YES	NO	
Brain Injury…….	YES	NO	
Chronic Sinus……..	YES	NO	
Convulsions…….	YES	NO	
Diabetes……..	YES	NO	
Ear Infections…….	YES	NO	
Epilepsy……..	YES	NO	
Fainting…….	YES	NO	
Hearing Disorder……..	YES	NO	
Heart Trouble…….	YES	NO	
Kidney Trouble…….	YES	NO	
Liver Problems…….	YES	NO	
Nervous Disorder…….	YES	NO	
Rheumatic Fever…….	YES	NO	
Tuberculosis…….	YES	NO	

9. Is there anything else we should know about your child's health?

_____

CHILD DENTAL HISTORY

1. Reason for today's visit?_____

2. Previous Dentist/Pedodontist?_____
   Name Address Phone

3. Reason for leaving last Dentist?_____

4. Is this your child's first dental visit?_____

5. Date of last cleaning?_____ Date of last X-Ray's?_____

6. Describe, if applicable, any unfavorable dental experiences_____

7. Has child ever received local anesthetic?_____

8. Does your child have:

			COMMENTS
Cavities detected but not treated…..……	YES	NO	
Teeth extracted but no appliance placed.……	YES	NO	
A finger sucking or pacifier problem……..…….	YES	NO	
A mouth breathing or tongue thrusting habit……...	YES	NO	
Prolonged dependence on milk bottle or nursing..…..	YES	NO	
Unusual speech habits…….……	YES	NO	
Difficulty brushing teeth daily…...……..	YES	NO	
A tooth or gum ache…….……	YES	NO	

9. Does your child:

Lack Sealants on permanent molars……..……..	YES	NO	
Lack Dietary Fluoride…….……	YES	NO	
Participate in contact sports…….……	YES	NO	
Grind or clench teeth……..……	YES	NO	

I certify that the above medical and dental information for my child is complete and accurate.

Parent/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____