

# Welcome

Patient ID # \_\_\_\_\_ Today's Date \_\_\_\_\_

*to our practice! We strive to make each  
of your child's visits pleasant and comfortable.  
Please fill out this form completely in ink.*

## Your Child

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

## Who is responsible for making appointments?

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Best time to call \_\_\_\_\_  
Time \_\_\_\_\_ Days \_\_\_\_\_

## Mother

☐ Stepmother ☐ Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

## Father

☐ Stepfather ☐ Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

**Marital Status** ☐ Single ☐ Married ☐ Divorced  
☐ Widowed ☐ Separated

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## Primary Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check  
☐ Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____	How often does your child floss? _____
Is your child's water fluoridated?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child take fluoride supplements?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child:	
Suck thumb/finger ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Chew hard objects (pencils, etc.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Suck/Bite lip ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Grind teeth ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Bite/Chew nails? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Clench jaws ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous dentist _____	Address _____
Date of last dental visit? _____	
Has your child had difficulty with previous dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's physician _____	Address _____
Phone # _____	
Previous Hospitalizations/Surgeries/Serious Illnesses? _____	When? _____
_____	_____
_____	_____

Is your child currently taking medications? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please list) _____
Has your child ever taken Fen-Phen/Redux? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please describe) _____	
Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____	

Has your child ever had any of the following:	
Asthma ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach, liver or kidney problems ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	Convulsions/Epilepsy ..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain any medical problems that your child has: _____	

Authorization & Release

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 dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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.

Signature of patient (or parent/guardian if minor) _____	Date _____
Dentist Review: _____	

Signature of Dentist _____	Date _____
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