Welcome

We are pleased to Welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Patient Name : ____ Date: ______________

DOB: _______ Nick Name: ____________ Sex: M/F Age:________ School Name: _______________________________

Grade: __________ Home Address: ____

Name & Age of Siblings: ____

Favorite TV Show: ____________________________ Favorite Pet: ________________

Favorite Hobby:___________________Responsible Party:____

Whom May We Thank you For Referring You? ____

Parents Marital Status: Married _____ Single _____ Divorced _____ Widowed_____ Partners: ______

Family Information

Father/Guardian's Name:______________________________________

Address:

____

____

Home Phone: _________________Work Phone: _______________

Occupation: _______________________ Cell Phone: ____________

Employer: ____

Social Security: ________________________DOB: ______________

Mother/Guardian's Name:______________________________________

Address:

____

____

Home Phone: _________________Work Phone: _______________

Occupation: _______________________ Cell Phone: ____________

Employer: ____

Social Security: ________________________DOB: ______________

Insurance

Do you have Dental coverage: Yes _____ No ______

Plan Name____

Phone: __________________

Member ID #: ________________________________

Group #: _______________________________________

Do you have Dental coverage: Yes _____ No ______

Plan Name____

Phone: __________________

Member ID #: ________________________________

Group #: _______________________________________

Dental History

Name of Previous Dentist: ____ Last X-rays Taken: _________________________

Has Child Complained of any Dental Problems: Yes____ No____

Is Fluoride Taken in Any Form: Yes _____ No_____ How: ________ Does child brush daily: Yes____ No____ How Many Times: _____

Any injuries to mouth, teeth, head: Yes___ No___ IF Yes What: ________________________________

Do you assist your child with brushing: Yes______ No_____ Flossing? Yes ____ No ____

Any unhappy Dental experiences: Yes ____ No ____ What: ____

Any mouth habits (i.e. Thumb sucking, mouth breathing, pacifier, sleeping with a bottle, grinding, nail-biting, or other)

____

PLEASE COMPLETE BOTH SIDES

Medical History

Child's Physician:____ Address: ____________________________________ Phone:___________________________

Date of Last Physical Exam: ________________________ Results: _____________________________________

Is Child under care of physician Now: Yes ______ No _____ If Yes., why? ____

Name of Specialist: ____ Phone Number of Specialist: __________________________________

Receiving any medication or drugs: Yes ______ No _______ If Yes, what: _________________

Ever been hospitalized: Yes _____ No _____

Ever had surgery: Yes _____ No ____ If yes, what: ______________________________

Allergies: Penicillin _____ Latex ______ Local Anestehtics______ Aspriin ____ Nuts ____ Foods____ Other: _______________________________

Would you like to talk privately to the dentist about any health Issues: Yes _____ No _____

Has your child had any history or difficulty with any of the following? If yes please check the following:

____ADD/ADHD	___CANCER	___EPILEPSY	___KIDNEY DISEASE
____ ANEMIA	___CEREBRAL PALSY	___FAINTING	___LIVER DISEASE
___ ASTHMA	___ CLEFT LIP	___HEARING PROBLEMS	___RHEUMATIC FEVER
___AUITISM	___DEVELOPMENTAL DELAYS	___ HEART PROBLEMS	___SEIZURES
___ BLADDER/KIDNEY PROBLEMS	___DIABETES	___ HEPATITIS	___SINUS PROBLEMS
____EXCESSIVE BLEEDING	___DRUG/ALCOHOL ABUSE	___ HIV/AIDS	___SPEECH PROBLEMS
___THYROID DISEASE	___TUBERCULOSIS		

OTHER? PLEASE EXPLAIN: ____

Perinatal & Behavioral History

Child was born at how many weeks gestation? _____________ Describe:

____

Any problems or complications during pregnancy/delivery? Yes ______ No _________

Does your child have any emotional or behavioral problems? Yes _______ No ________

Does your child have any sensitivities to sound, taste, etc. Yes ________ No __________

Do you anticipate your child having difficulties accepting dental treatment? Yes _____ No _____

Explain: ____

Authorization

To the best of my knowledge., the above information is complete and correct. I understand that is my responsibility to infor my doctor if my minor or guardian ever has a change in health.

Minor/Child Consent

I am the parent, guardian or personal representative of

Child's Name (Print): :_______________________________________

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the Dental Staff to perform necessary dental services for the child names above, including but not limited to x-rays, and administration of anesthetics., which are deemed advisable by the doctor,. Whether or not I am present when treatment is rendered.

Insurance Assignment and Release

I certify that my dependent is covered by insurance. Please list name of Insurance Company ____

I hereby authorize payment directly to Adult and Pediatric Dental Studio for all insurance benefits otherwise payable to me for services rendered. I do not pay the entire new balance owed will be assessed each month. In case of the default of payment of this account. I agree to pay collection late charge on the balance owed will be assessed each month. In the case of default of payment of this account. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.. I understand that my dental insurance may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I authorize the above provider of services to release information required to recure the payment of benefits. Payment is due at the time of the service. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Date: ____________________________________