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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.

Date: _____ Child's Birthdate: _____

Child's Name:_____ Sex: □ M □ F Age: _____
Last name First name

Nickname: _____ Hobbies: _____ Parent's Cell :_____

Home address: _____
Street City State Zip

Mailing address (IF Different from above:_____
Street City State Zip

School Name: _____ School Phone ( ) _____

Person Financially Responsible: _____ Work# _____ Home#: _____

Whom may we thank for referring you? _____Phone # _____

INSURANCE INFORMATION

Father's/ Guardian Info:	Mother's/ Guardian Info:
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Home#: ( ) _____ (if different from above)	Home#: ( ) _____ (if different from above)
Work#: ( ) _____ (if different from above)	Work#: ( ) _____ (if different from above)
Email: _____	Email: _____
SS#: _____ Birthdate: _____	SS#: _____ Birthdate: _____
Do you have dental insurance for child: □ Y or □ N	Do you have dental insurance for child: □ Y or □ N
Plan Name: _____ Phone#:_____	Plan Name: _____ Phone#:_____
Address: _____	Address: _____
Policy #: _____ Group#: _____	Policy #: _____ Group#: _____

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

DENTAL HISTORY

Has child complained about dental problems?	□ Y or □ N	Is fluoride taken in any form?	□ Y or □ N
Does your child brush teeth daily?	□ Y or □ N	Any injuries to mouth, teeth, head?	□ Y or □ N
Does child use floss every day?	□ Y or □ N	Any unhappy dental experiences?	□ Y or □ N
Any learning problems?	□ Y or □ N	Any school problems?	□ Y or □ N

Any mouth habits? Thumb sucking, nail biting, Grinding, mouth breathing, pacifier, sleeping with bottle, etc. □ Y or □ N

MEDICAL HISTORY

Child's Name: _____ **Date: _____**

Pediatrician: _____ Address and Phone#: _____

Is child under care of a physician now?	□ Y or □ N	Medications: _____
Receiving any medication or drug?	□ Y or □ N	_____
Ever been hospitalized?	□ Y or □ N	Allergies: _____
Ever had surgery?	□ Y or □ N	_____
Is there excessive bleeding when cut?	□ Y or □ N	

Has child had any history of or difficulty with any of the following? If yes, please mark (X)

□ A.I.D.S./H.I.V.	□ Cerebral Palsy	□ Epilepsy	□ Kidney Disease	□ Rheumatic fever
□ Anemia	□ Chicken Pox	□ Fainting	□ Liver Disease	□ Sinus Problems
□ Asthma	□ Convulsions	□ Hearing problems	□ Measles	□ Thyroid Problems
□ Bladder	□ Diabetes	□ Heart Problems	□ Mononucleosis	□ Tuberculosis
□ Cancer	□ Drug/Alcohol Abuse	□ Hepatitis	□ Mumps	□ Other

ATTENTION BEHAVIOR

□ ADHD □ ADD □ PDD □ HYPERACTIVITY □ OTHER

□ Autism Spectrum: _____
□ Sensory Issues: _____
□ Social Issues: _____

AUTHORIZATION

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

Minor/Child Consent:
I am the parent/guardian or personal representative of _____
Print child's name
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 named above.

Insurance Assignment and Release:
I certify that my dependent(s) is/are covered by insurance with _____
Name of Insurance Company
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 authorize the use of my signature on all insurance submissions.

The above referenced doctor may use my child's health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I have reviewed the offices" Notice of Privacy Practice" policy.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print Name of Parent, Guardian or Personal Representative Relationship to child