Welcome!

Thank you for your visit today! We are pleased to welcome you and your child to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask - we will be glad to help. We look forward to working with you to maintain your child's dental health!

PATIENT INFORMATION

Date ____________ Home phone ____

Name ____ Nickname ____

Sex Male ___ Female ___ Age ___ Date of Birth __________

Home Address ____ Town ________________ Zip __________

E - Mail Address ____

Person financially responsible _________________________ Home Phone __________ Work Phone __________

Whom may we thank for referring you? ____

Name of your dentist? ____________________________________ City/state ___________________________________

INSURANCE

Father's/Guardian's Name ___________________________________

Address(if different from patient's) ____________________________

____

Home phone _____________ Work phone ____________________

Employer ____

Social Security # ____________ Date of Birth ____________________

Do you have orthodontic insurance/coverage for your child? (YES/NO)

Plan Name ____

Address ____

Phone number _____________________________________

Group # ___________________________________

Policy # __________________________________

Mother's/Guardian's Name ___________________________________

Address(if different from patient's) ____________________________

____

Home phone ___________ Work phone ____________________

Employer ____

Social Security # ___________ Date of Birth _______________

Do you have orthodontic insurance/coverage for your child? (YES/NO)

Plan Name ____

Address ____

Phone number ________________________

Group # ____________________________

Policy # ____________________________

DENTAL HISTORY

Date of last dental visit? __________ For what service? ____

Has your child complained about dental problems? (YES/NO)

Does your child brush teeth daily? __________ (YES/NO)

Does your child floss teeth daily? __________ (YES/NO)

Is fluoride taken in any form? __________ (YES/NO)

Any injuries to mouth, teeth, or head? ____ (YES/NO)

Any unhappy dental experiences? ________ (YES/NO)

Does your child have frequent headaches? (YES/NO)

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ______________________________

Please Complete Both Sides

MEDICAL HISTORY

Patient's physician ______________________ City/State Phone

Date of last physical examination ____________ Results ______________________________

____

Is your child under the care of a physician now? --- YES/NO

Receiving any medications or drugs? ------------- YES/NO

Ever had surgery or been hospitalized?----------- YES/NO

Is there excessive bleeding when cut?-------------- YES/NO

Do you take antibiotics for dental cleanings?---- YES/NO

Medications ______________________________

____

Allergies ______________________________

____

____

HAS YOUR CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (X)

__AIDS/HIV	__ Cerebral Palsy	__Epilepsy	__ Mumps
__Anemia	__ Chicken Pox	__Fainting	__ Sinus Problems
__Asthma	__ Convulsions	__Hearing Problems	__ Thyroid Disease
__Bladder problems	__ Diabetes	__Heart Problems	__Liver Disease
__Cancer	__ Drug/Alcohol abuse	__Hepatitis	__ Measles
__Mononucleosis	__ Rheumatic Fever	__Kidney Disease	__ Other

EMERGENCY INFORMATION

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

Name ______________________ Relationship ____________ Phone ____________

Name ______________________ Relationship ____________ Phone ____________

AUTHORIZATION

I have recieved this Questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for myself, and I agree to notify the dentist if any changes in child's health status should occur.

I authorize the dentist / staff to perform the necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents at time of treatment, unless prior arrangements have been approved.

Parent / Guardian Signature ______________________________ Date ____________

Welcome!