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!



