Patient Information

Date ______________

Patient's Name ______________ Last ______________ First ______________ Middle

Nickname ______________ Age ______ ☐ Male ☐ Female

Date of Birth ______________

____

Responsible Party

Name ______________ Last ______________ First ______________ Middle ______________ Marital Status

Residence ______________ Street ______________ City ______________ State ______________ Zip

Mailing Address ______________ Street ______________ City ______________ State ______________ Zip

How long at this address? ______ Home Phone ______________ Work Phone ______________

e-mail ______________ cell phone (Mother) ______________ (Father) ______________

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______

Spouse's Name ______________ Last ______________ First ______________ Middle ______________ Relationship to Patient

Employer ______________ Occupation ______________ No. Years Employed ______

Social Security # ______________ Birthdate ______________ Work Phone ______________

Insurance Information

Dental Insurance Co.: ______________

Insurance Address: ______________

Employee Name/I.D.: ______________

Employee S.S. # ______________

We welcome open discussion of services and fees prior to treatment. It is our office policy that services rendered are paid in full at the time of service. If there are insurance benefits, as a courtesy we will submit your insurance claim and you are required to pay your estimated portion, in addition you are responsible for any remaining balance after 30 days and you may incur finance charges.

I, ______________, represent that I am legally entitled to obtain medical/dental

services for ______________, and I give consent for treatment.
Child's Name

____
Parent's Signature
(Relationship if other than parent signing)

I understand that, where appropriate, credit bureau reports may be obtained.

____
Parent's Signature
(Relationship if other than parent signing)

____
Date

BROTHERS ______________________ SISTERS ______________________

CHILD'S PHYSICIAN ______________________ PHONE # ______________________

FAMILY DENTIST ______________________ PHONE # ______________________

IS YOUR CHILD IN GOOD GENERAL HEALTH? YES ________ NO ________

IS YOUR CHILD SEEN ROUTINELY BY A PHYSICIAN? YES ________ NO ________

IF YES, WHY...

____

____

NAME OF PERSON WHO REFERRED YOU TO OUR OFFICE: ______________________

CIRCLE ONE: Dentist Physician Friend Other

HAS YOUR CHILD HAD ANY DIFFICULTY WITH OR HISTORY OF (Circle Y or N):

sickle cell anemia	Y	N	seizures	Y	N
anemia	Y	N	blood disorder	Y	N
arthritis	Y	N	cerebral palsy	Y	N
cancer	Y	N	heart trouble	Y	N
skin rash	Y	N	rheumatic fever (heart murmur)	Y	N
radiation treatment	Y	N	allergies	Y	N
nitrous oxide (laughing gas)	Y	N	diabetes	Y	N
convulsions/epilepsy	Y	N	asthma	Y	N
kidney disorders	Y	N	hepatitis/AIDS	Y	N
liver disorders	Y	N	local anesthesia (novacain)	Y	N
slow learner/delayed development	Y	N			

IS YOUR CHILD TAKING MEDICINE? IF SO, FOR WHAT? ______________________

HAS YOUR CHILD HAD ANY UNFAVORABLE REACTIONS OR ALLERGY TO DRUGS, INCLUDING ANTIBIOTICS (penicillin) or LOCAL ANESTHETIC SOLUTION? YES ________ NO ________

HAS YOUR CHILD ANY HISTORY OF:	YES	NO	CURRENT
fingersucking / thumbsucking	________	________	________
prolonged breast or bottle feeding	________	________	________
pacifier past age 2 yrs	________	________	________
mouth breathing or nasal obstruction	________	________	________

CHIEF PURPOSE OF THIS DENTAL VISIT ______________________

IS YOUR CHILD IN PAIN NOW? ______________________

HAS YOUR CHILD HAD ANY PREVIOUS DENTAL TREATMENT? ______________________

HAS YOUR CHILD HAD ANY UNFAVORABLE DENTAL OR MEDICAL EXPERIENCE? ______________________

IF YES, PLEASE EXPLAIN. ______________________

____

____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices

______________________ ________ ______________________ ________

Signature of Patient or Legal Representative Date Printed Name of Legal Representative Relationship