Today's date_____

Welcome to Our Practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex_____

Birthdate_____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____

State/Province _____ Zip/Postal Code_____

Phone_____

❑ **Mother** ❑ Stepmother ❑ Guardian

Name _____

Home Phone_____

Cell Phone _____

Work Phone _____

SS#/SIN _____

Employer _____

Occupation _____

❑ **Father** ❑ Stepfather ❑ Guardian

Name _____

Home Phone_____

Cell Phone _____

Work Phone _____

SS#/SIN _____

Employer _____

Occupation _____

Parent/Guardian's Marital Status

❑ Single ❑ Married

❑ Divorced ❑ Widowed ❑ Separated

Who is responsible for making appointments?

Name _____

Relationship_____

Primary Dental Insurance

Insured's Name _____

Relationship_____

Birthdate_____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group No. _____ Emp. No. _____

Ins. Company Address_____

Does your child have a secondary dental insurance policy? ❑ Yes ❑ No
If yes, please provide card.

Financial Agreement

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or appropriate health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group benefits otherwise payable to me. 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 my behalf or my dependents. Payment is due as services are rendered unless prior arrangements have been made. In the event this account is placed with a collection agency, I agree to pay 35% of the principal and interest owing on said account as liquidated damages, and an additional 15% of the principal and interest owing as attorney's fees, for collecting said account.

Signature of parent/guardian _____ Date _____

Over Please

Child's Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Other _____
❑ Arthritis	❑ Cerebral Palsy	❑ Growth Problems	❑ Kidney	❑ Rheumatic fever	_____
❑ Asthma	❑ Chicken Pox	❑ Hearing	❑ Latex allergy	❑ Seizures	_____
❑ Asperger's	❑ Chronic Sinusitis	❑ Heart	❑ Liver	❑ Sickle cell	_____
❑ Autism	❑ Diabetes	❑ Hepatitis	❑ Measles	❑ Thyroid	_____
❑ Bleeding disorders	❑ Earaches	❑ HIV +/AIDS	❑ Mononucleosis	❑ Tuberculosis	_____
❑ Bones/Joints	❑ Epilepsy				

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

	YES	NO
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	❑	❑
If yes, please list: _____		
2. Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3. Is the child allergic to anything else, such as a certain food? If yes, please explain: _____	❑	❑
4. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
5. Has the child ever been hospitalized?	❑	❑
6. Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
7. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
8. Has the child had any problem with dental treatment in the past?	❑	❑
9. Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
10. Has the child had any orthodontic treatment?	❑	❑
11. What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
12. Does the child take fluoride supplements?	❑	❑
13. Any conditions not mentioned here? If yes, please list: _____	❑	❑

Consent to Treat

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. **It is my responsibility to inform this office of any changes in my child's health status.** I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize the dentist to perform any and all forms of dental procedures that may be indicated in connection with my child's treatment. I also understand the use of local anesthetic agents have the potential for complications including but not limited to infection, allergic reaction, persistent and/or partial numbness, and hematoma.

Signature of parent/guardian _____ Date _____