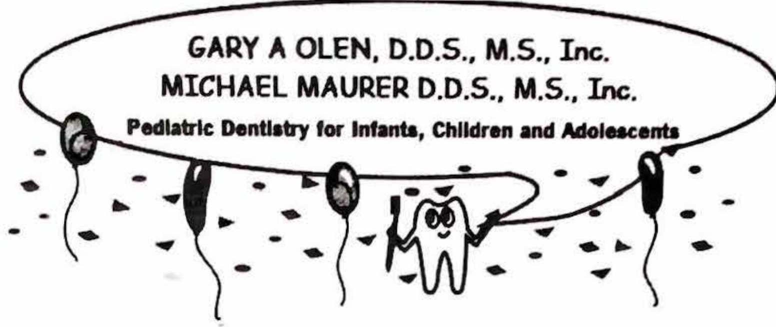

General Information

Child's full name________________________ Nickname________________
Sex: F______M______childs date of birth______________ Age________
Address________________________Apt.#______City/State______________Zip__________
Home phone________________Mother's cell________________Father's cell________________
Email Address:________________________
Whom may we thank for referring you to our office?________________________
Father's Full Name________________Social Security______________D.O.B__________
Employed By________________________Occupation________________
Address________________________Business phone________________
Mother's Full Name________________Social Security______________D.O.B__________
Employed By________________________Occupation________________
Address________________________Business phone________________
Married________ Widowed________ Divorced________ Separated________ Single________
Person Responsible for Childs Account________________________
Names and ages of Brothers and Sisters________________________
Previous Dentist________________Address________________________
Date of Last Dental Treatment________________________
Name of Father's Dental Insurance________________________Group #________________
Name of Mother's Dental Insurance________________________Group #________________

Health Questionnaire

State condition of child's health-please be specific________________________
Has your child ever been under the care of a physician? If yes, state why and when and the name of the physician________
____
Has your child received medication in the past other than antibiotics? If yes, for what and when?________________
Has your child received a blood transfusion or blood products?________________
Is your child a carrier of any infectious disease?________________________
Has your child had any history of the following: heart trouble, rheumatic fever, brain injury, diabetes, hepatitis, convulsions, temper tantrums, seizures, asthma, bleeding disorders, AIDS, HIV, ARC? (please indicate)________________
Is your child adopted?________________________
Is your child allergic to penicillin, anesthetic, any medication or food?________________
Is your child taking a fluoride vitamin or fluoride tablet?________________
Has your child had fluoride put on his or her teeth?________________
Has your child experienced any unfavorable or unpleasant reaction from previous dental or medical care?________
Has any member of the family ever had an unusual dental history, such as missing or extra teeth?________
Has there ever been any injury to any of your child's teeth by fall, blow, bump or otherwise?________
Does your child have any habits such as thumbsucking, nailbiting, lip or cheek biting? Please indicate________
What school does your child attend?________________________
Are there any health or other problems you feel should be brought to the attention of the doctor?________
State name, address and phone number of child's physician________________________
I hereby certify the foregoing information is true and correct.
Signature________________________Date________________
Relationship to patient________________________

CONSENT-RESPONSIBILITY

1. I authorize the specialists to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with my child. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the specialist choose and employ such assistance as deemed fit to provide recommended treatment.
2. I understand that all responsibility for payment for dental services provided in this office to my child, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.
3. I understand that where appropriate, credit bureau reports may be obtained.
4. I authorize the use of my social security number to file my child's dental claim.

*Parent/GuardianSignature*________________________Date________________
Please Print________________________