Welcome
To our office

Your Child

Child's name: _____ Nickname: _____
First Last
Birthdate: _____ Sex: _____ Age: _____
School: _____ Grade: _____
Child's Home address: _____
City _____State_____ Zip_____ Phone _____

About Parents

Mother: _____ Father:_____
Mother's phone: _____ Father's phone: _____
Mother's cell phone: _____Father's cell phone: _____
Mother's address _____ Father's address_____
_____ _____
Employer: _____ Employer: _____
Address: _____ Address: _____
Work # _____ Work #_____

Health History

Has your child had difficulty with previous visits? _____
Does your child need pre-medication before any dental treatment? _____
Is your child taking any medication at this time? _____
Has your child ever had any of the following: (please circle)

Asthma Cancer Hepatitis HIV/AIDS
Hemophilia Diabetes Rheumatic Fever Heart Murmur
Congenital Heart Defect Handicaps/Disabilities Convulsions/Epilepsy
Tuberculosis Abnormal Bleeding Cancer/Chemo treatments

Is your child allergic to any of the following?

Latex Codeine Dental Anesthetics Erythromycin
Cinnamon Peppermint Metals Penicillin
Tetracycline

*Please list any other drugs that your child is allergic to :*_____

Child's Habits

How often does your child brush? _____ How often does your child floss? _____
Date of last dental visit? _____ Previous Dentist _____
Child's Physician _____ Phone #: _____
Is your child's water fluoridated? Yes No

Does your child:

Suck thumb/finger Yes No
Bite/Chew nails Yes No
Suck/bite lips Yes No
Grind Teeth Yes No
Clench Jaws Yes No

Dental Insurance Coverage

Primary

Insured's name: _____ Insured's birthdate _____

Insured's SS #_____ Relation: _____

Insured's Employer _____

Insurance Co. Name: _____

Insurance Co. Address _____

Insurance Co. Phone# _____

Group # (Plan, Local, or Policy #) _____

Secondary

Insured's name: _____ Insured's birthdate _____

Insured's SS# _____ Relation _____

Insured's employer _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (plan, Local or Policy #) _____

In the event of an emergency, is there someone who lives near you that we should contact? _____ Name: _____

Work #_____ Home #_____

Payment Policy

Payment for each visit is requested as services are rendered. Our office will accept cash, check or Mastercard, Discover or Visa Card. If you have dental insurance, we will wait for the insurance to pay us for cleanings, examinations, and x-rays. For other services such as fillings, crowns, bridges, dentures and partials, we will ask for fifty percent of the charges the day services are rendered. After the insurance has paid their percentage, we will bill the remaining balance to you. In case of overpayment, we will reimburse you. If you have a secondary insurance we will send this in for you. **Attention**: With our new computer program we cannot bill two accounts for families of divorce. If you are responsible to pay a certain amount please do so at the visit and tell the other party to pay the remainder. We cannot be responsible to bill both parties involved. Whichever of the parents bring in the child/children is responsible to make payment arrangements at the time of appointment.

If for some reason you cannot make prompt payment, please discuss the matter with the office staff before services are rendered so that a payment plan can be arranged for you.

I understand that the information that I have given today is correct to the best of my knowledge. I will inform your office of any medical history changes. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____