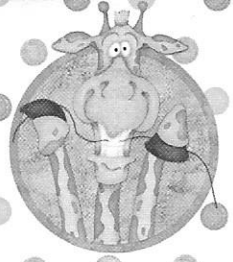


WELCOME

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS# / SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Email _____

Phone _____ SS#/SIN _____

DL# _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Day _____

_____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____ D.O.B. _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____ State/ Zip/

City _____ Prov. _____ P.C. _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____ State/ Zip/

City _____ Prov. _____ P.C. _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX

☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

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

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated?..... ☐ Yes ☐ No Does your child take fluoride supplements?..... ☐ Yes ☐ No

Does your child:

Suck thumb/finger..... ☐ Yes ☐ No Grind teeth ..... ☐ Yes ☐ No

Suck/Bite lip..... ☐ Yes ☐ No Clench jaws ..... ☐ Yes ☐ No

Bite/Chew nails ..... ☐ Yes ☐ No Gag easily..... ☐ Yes ☐ No

Chew hard objects (pencils, etc.).....☐ Yes ☐ No Tonsils/Adenoids removed _____ age ..... ☐ Yes ☐ No

Speech Problem..... ☐ Yes ☐ No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

Has your child ever taken FenPhen/Redux? ☐ Yes ☐ No

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐ No

_____

Has your child ever had any of the following:

Asthma ..... ☐ Yes ☐ No Stomach, liver or kidney problems ..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No Handicaps/Disabilities..... ☐ Yes ☐ No

Hepatitis ..... ☐ Yes ☐ No Tuberculosis..... ☐ Yes ☐ No

HIV/AIDS ..... ☐ Yes ☐ No Diabetes ..... ☐ Yes ☐ No

Hemophilia..... ☐ Yes ☐ No Rheumatic Fever..... ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ..... ☐ Yes ☐ No Congenital Heart Defect..... ☐ Yes ☐ No

Heart Murmur ..... ☐ Yes ☐ No

Convulsions/Epilepsy ..... ☐ Yes ☐ No

Osteoporosis..... ☐ Yes ☐ No

Abnormal Bleeding..... ☐ Yes ☐ No Hearing Impairment ..... ☐ Yes ☐ No

Acid Reflux ..... ☐ Yes ☐ No Handicap/Disabilities ..... ☐ Yes ☐ No

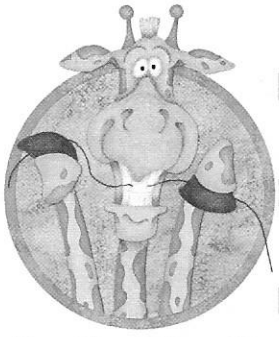
Please explain any medical problem that your child has: _____

_____

Authorization & Release

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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.



_____ _____

Signature of patient (or parent/guardian if minor) Date

Dentist Review

_____ _____

Signature of Dentist Date