WELCOME!

1. PATIENT INFORMATION

Patient's Name _____ Sex ☐M ☐F DOB _____ Age ____ Height _____ Weight _____
First Middle Last Month / Day / Year Inches lbs

Home Address _____ City _____ State _____ Zip _____

2. PARENT/GUARDIAN INFORMATION

Parent/Guardian _____ Relationship to child _____ Parent/Guardian DOB _____
Month / Day / Year

Cell Phone (_____)_____ Home Phone (_____)_____ Email _____

Emergency Contact Name _____ Relationship to child _____ Cell Phone (_____)_____

Your Employer _____ Work Phone (_____)_____ How did you hear about us?_____

3. DENTAL INSURANCE INFORMATION *(Primary Carrier)*

Insured's Name _____

Insured's SSN _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insured's Member ID _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

4. DENTAL INSURANCE INFORMATION *(Secondary Carrier)*

Insured's Name _____

Insured's SSN _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insured's Member ID _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

5. FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards, or one of the third-party financing options we provide.

☐ **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, credit card or one of the third-party financing options we provide.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

For a detailed description of our privacy practices, please see our "Notice of Privacy Practices" folder at the front desk.

Consent

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____
Patient Signature/Legal Guardian *Date*

6. AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize the following person to have access to information covered under the Privacy Practice regarding myself.
Your Name

_____ _____
Name (Printed) Relationship to child

7. DENTAL HISTORY **Please mark (x) on any of the following conditions that apply to your child**

Patient Name (print):

☐ Inherited dental characteristics ☐ Bad breath ☐ Toothache ☐ Jaw join problems (popping, etc.) ☐ Bleeding gums
☐ Cavities/decayed teeth ☐ Mouth sores or fever blisters ☐ Excessive gagging ☐ Injury to teeth, mouth or jaws ☐ Clinching, grinding teeth

For each checked box, please describe _____

Does your child have a sucking habit after one year of age? ☐ Y ☐ N If yes, which? ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other ☐ For how long? _____

Is there a family history of cavities? ☐ Y ☐ N If yes, indicate all that apply ☐ Mother ☐ Father ☐ Brother ☐ Sister

How often does your child brush his/her teeth? _____ times per _____ How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily

What is your primary concern about your child's oral health? _____

How frequently does your child have the following?

Snacks between meals	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _____
Candy or other sweets	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Type _____
Chewing gum	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Usual snack _____
Soft drinks*	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _____

(*such as juice, fruit-flavored drinks, sodas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Does your child participate in sports or similar activities? ☐ Y ☐ N If yes, list _____

Does your child wear a mouthguard during these activities? ☐ Y ☐ N If yes, type _____

Has your child been examined or treated by another Dentist? ☐ Y ☐ N

If yes, Date of first visit _____ Date of last visit? _____ Reason for last visit? _____

Were X-rays taken of the teeth or jaws? ☐ Y ☐ N Date of most recent dental X-rays _____

Has your child ever had orthodontic treatment (braces, spacers or other appliances?) ☐ Y ☐ N If yes, when? _____

Has your child ever had a difficult dental appointment? ☐ Y ☐ N If yes, describe _____

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

8. MEDICAL HISTORY **Please mark (x) as your response to indicate if your child has or have had any of the following**

☐ Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions
☐ Sinusitis, chronic adenoid/tonsil infections
☐ Sleep apnea/snoring, mouth breathing, or excessive gagging
☐ Congenital heart defect/disease, heart murmur, rheumaric fever or rheumatic heart disease
☐ Irregular heart beat or high blood pressure
☐ Asthma, reactive airway disease, wheezing, or breathing problems
☐ Cystic fibrosis
☐ Jaundice, hepatitis, or liver problems
☐ Bladder or kidney problems
☐ Impaired vision, visual processing, hearing, or speech
☐ Developmental disorders, learning problems/delays, or intellectual disability
☐ Cerebral palsy, brain injury, epilepsy, or convulsions/seizures
☐ Autism/autism spectrum disorder
☐ Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)
☐ Attention deficit/hyperactivity disorder (ADD/ADHD)
☐ Behavioral, emotional, communication, or psychiatric problems/treatment
☐ Abuse (physical, psychological, emotional, or sexual) or neglect
☐ Diabetes
☐ Thyroid or pituitary problems
☐ Anemia, sickle cell disease/trait, or blood disorder
☐ Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant
☐ Hemophilia, bruising easily, or excessive bleeding
☐ Mononucleosis, tuberculosis (TB), scarlet fever, cyromegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS

For each checked box, provide details here _____

_____

Physician Full Name _____ Phone (_____)_____

Is your child being treated by a physician at this time? ☐ Y ☐ N If yes, reason _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ Y ☐ N If yes, list name, dose, frequency & date started

_____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? If yes, list date & describe _____

_____

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? ☐ Y ☐ N If yes, list _____

_____

Is your child allergic to latex or anything or anything else such as metals, acrylic, or dye? ☐ Y ☐ N If yes, list _____

Is your child up to date on immunizations against childhood diseases? ☐ Y ☐ N

Is there any other significant medical history pertaining to this child or his/her family that the Dentist should be told? ☐ Y ☐ N If yes, describe _____

_____

Consent

I hereby authorize Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand, and agree to the above terms and conditions.

_____ _____ _____

Signature of Patient/Legal Guardian *Print Name* *Date*

_____

Dentist/Hygienist Signature