Chart #: _____
FOR OFFICE USE ONLY

Child's Information

Child's Name: _____ Date: _____
Last First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Gender: _____

Phone (Home): _____ Parent's Contact #: _____
Parent's Name: _____ Parent's Social Security #: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

School : _____ Grade: _____
Hobbies, Sports and Interests: _____

Dental Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Does the child have or use any of the following? Please check those that apply:

- ☐ Traumatic injury to mouth/teeth
- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ears
- ☐ Bad breath
- ☐ Unfavorable dental experience
- ☐ Topical fluoride treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e. fingernail biting, cheek biting, etc.
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental floss
- ☐ Fluoride supplements
- ☐ Between meal snacks
- ☐ Well balanced diet

Health Information

Does the child have or has the child had any of the following? Please check those that apply:

- ☐ Allergies _____
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Hay Fever / seasonal allergies
- ☐ Heart ailment
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Physical or mental handicap
- ☐ Psychiatric care/emotional problems
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Thyroid disorders
- ☐ Ulcer or Colitis
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

- Has the child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Has the child ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Is the child under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Describe any current medical treatment including **any medications** taken, even though not listed above_____
  _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is any change in the health of the child, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Name of parent or guardian (please print) Signature Relationship to patient

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Insurance Information

Primary

Name of *Insured*: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ Social Security #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Additional Insurance

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ Social Secruity #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Minor/Child Consent

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform any necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ Date: _____ Relationship to Patient: _____
Signature of parent or guardian

Emergency Contact:
Name _____ Phone # _____ Relationship to Patient: _____