



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

## PATIENT INFORMATION

Date \_\_\_\_\_ SS/HIC/Patient ID # \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Minor/Child \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Nickname \_\_\_\_\_ Hobbies \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Name \_\_\_\_\_ School Phone (\_\_\_\_) \_\_\_\_\_

Person financially responsible \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Father's/Guardian's Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

(if different from above) (if different from above)

E-mail \_\_\_\_\_

Employer \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mother's/Guardian's Name \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

(if different from above) (if different from above)

E-mail \_\_\_\_\_

Employer \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # \_\_\_\_\_

## DENTAL HISTORY

Date of last visit to a dentist \_\_\_\_\_ For what service? \_\_\_\_\_

	YES	NO		YES	NO
Has child complained about dental problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? .....					



Minor/Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

	YES	NO	
Is Minor/Child under care of physician now? .....	<input type="checkbox"/>	<input type="checkbox"/>	Medications _____
Receiving any medication or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V.  | <input type="checkbox"/> Cerebral Palsy     | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles        | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Mononucleosis  | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Other           |

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

#### Minor/Child Consent

I am the parent, guardian, or personal representative of \_\_\_\_\_

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

#### Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.



Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

#### TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe \_\_\_\_\_

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list \_\_\_\_\_

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_



### **Cancellation Policy:**

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of our dental services as economical as possible. The appointment you scheduled is reserved for you and your treatment only. When you fail to keep your appointment without providing us with adequate notice, it adds to the overall cost of care as trained professional and dental facilities that are not being utilized.

### **Policy and Fees:**

1. If you are unable to keep your scheduled appointment, please give us 48 hours to allow us the time to fill out schedule with other patients who may be waiting for an appointment.
2. If less than 48 hours notice is given, you will be expected to pay for the appointment cancellation fee of \$50.00
3. No show for an appointment will be charged a \$50.00 fee for failure to notice.
4. Cancellation policy fee is not covered by your insurance. It will be your responsibility to pay this fee.
5. If missed appointment becomes a repetition, any future appointments that you will make will have to wait an hour or more.
6. As a courtesy to you, we will make every effort to confirm your reserved appointment. Please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is your responsibility to keep your reserved appointment or contact us 48 hours in advance to reschedule or cancel your appointment.

We appreciate all of our patients understanding and consideration regarding our cancellation policy. If you have any questions or concerns; please do not hesitate to ask us.

I, \_\_\_\_\_, have read the cancellation policy and understand the information mentioned above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_