Today's Date:_____/_____/_____

Name: (Last, First, Middle)

_____

Nickname:_____ Sex: __M / F___

Birthdate:____/_____/_____ Age:_____

School:_____Grade:_____

Phone #: _____

Address:_____

_____

Primary Dental Insurance

Co. Name:_____

Address:_____

_____

Phone #: _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

Phone #: _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ DOB: _____

Insured's Employer:_____

Who is accompanying this child today and what is the relation?

_____

Mother's Name:_____

Address:_____

_____

Home #:_____Work#:_____

SS#_____ DOB:_____

Father's Name: _____

Address:_____

_____

Home #:_____Work #:_____

SS#:_____ DOB: _____

Person ultimately responsible for account

Name: _____

Relation to child: _____

Billing Address: _____

_____

SS #: _____ DOB: _____

Home #: _____

Cell #: _____

Payment method : cash check credit card

_____ I herby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Reason for today's visit: ____Exam ____Emergency ____Consultation

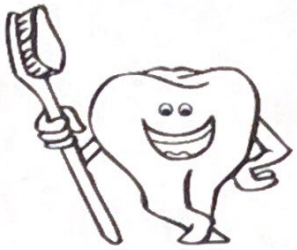
Is child in pain? ____No ____Yes How Long? _____

Does your child require pre-medication? _____Yes _____No _____ Don't Know

Previous Dentist_____ (___) _____

Last Dental Exam _____/_____/_____ Last Dental X-Rays ____/____/_____

Times a day child brushes? _____ Is the child's water fluoridated? ____Yes ____No



Is child taking any of the following medications? ____ Pain Killers (including Aspirin) ____Ritalin ____ Stimulants

____Blood thinners ____ Tranquilizers ____ Insulin ____ Muscle relaxers ____Others _____

Child's Physician Name:_____ (____)_____Last Medical Exam _____

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur
Y N Rheumatic Fever
Y N Artificial Heart Valves
Y N Congenital Heart Defect
Y N Scarlet Fever
Y N Surgeries/Operations
Y N Cancer/Tumors
Y N Chemotherapy
Y N Jaw Problems TMJ/TMD
Y N Hearing Problems
Y N Tonsillitis
Y N Respiratory Problems
Y N Asthma/Difficulty Breathing
Y N Blood Transfusion (s)
Y N Leukemia/Anemia
Y N Diabetes/Hypoglycemia
Y N Hemophilia
Y N Abnormal Bleeding
Y N Cleft Lip/Palate
Y N Birth Defects
Y N High/Low Blood Pressure
Y N Hepatitis
Y N Artificial Bone/Joints/Implants
Y N Liver/Kidney/Organ Problems
Y N HIV+/AIDS/ARC
Y N Tuberculosis TB
Y N Psychiatric Problems
Y N Hyper Active/ADD
Y N Fainting/Seizures/Epilepsy
Y N Cerebral Palsy

Please list any other medical condition (s) child has or ever had: _____

_____

Is child allergic to: ____Latex ____Penicillin/Amoxicillin ____Tetracycline ____ Dental Anesthetics (Novocaine)
____ Aspirin ____ Food allergies ____ Other (s): _____
Does this child do any of the following? ____Thumb/Finger Sucking ____ Tongue Thrusting/Sucking ____ Heavy Snoring
____ Mouth Breathing ____ Lip Sucking/Biting

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services render at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Initials

Signature _____ Date ____/____/____

____ Parent or Guardian ____ Other