Child Information Form

Patient ID # _____
Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's name _____ Sex _____ Age _____
Nickname _____ SS # _____ Birthdate _____
School _____ Grade _____
Child's Home Address _____
City _____ State _____ Zip _____ Phone _____

Responsible Party

Name _____ Relationship _____
Address _____ Email _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
SS # _____ DL # _____
Who is Responsible for Making Appointments?
_____

Parent or Guardian Information ☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

Name _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS # _____ DL # _____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

Name _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS # _____ DL # _____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS # _____
Employer _____ Date Employed _____ Occupation _____
Insurance Co. _____ Group # _____ Employee # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount Already Used _____ Max. Annual Benefit _____

Additional Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS # _____
Employer _____ Date Employed _____ Occupation _____
Insurance Co. _____ Group # _____ Employee # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount Already Used _____ Max. Annual Benefit _____

Dental / Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes count have an important interrelationship 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 flouride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb / Finger ☐ Yes ☐ No

Suck / Bite Lip ☐ Yes ☐ No

Bite / Chew Nails ☐ Yes ☐ No

Chew Hard Objects (pencils, etc.) ☐ Yes ☐ No

Grind Teeth ☐ Yes ☐ No

Clench Jaws ☐ Yes ☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

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

Has your child ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Patient ID # _____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No

Handicaps / Disabilities ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

HIV / AIDS ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No

Congenital Heart Defect ☐ Yes ☐ No

Abnormal Bleeding ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Stomach, Liver or Kidney Problems ☐ Yes ☐ No

Convulsions / Epilepsy ☐ Yes ☐ No

A persistant cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ Yes ☐ No

Child's Physician_____ Phone _____

Address _____

Previous Hospitalizations / Surgeries / Serious Illness When?

_____ _____

_____ _____

Is your child currently taking any medication? ☐ Yes ☐ No (If yes, please list) _____

Does your child have a history of allergies to any other substance (latex, environmental, etc)? _____

Please explain any medical problems that your child has: _____

_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Visa ☐ Mastercard ☐ I wish to discuss the office's payment policy

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been acurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authroize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information the diagnosis and the records of tratment or examination rendered to my child during the period of such care 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 dependants.

_____ _____

Signature of Patient (or Parent/Guardian if a minor) Date

Dentist's Review: _____

_____ _____

Signature of Dentist Date