

DENTISTRY



FOR CHILDREN, P.C.

ABOUT YOUR CHILD

CHILD'S NAME _____

NAME CHILD PREFERS TO BE CALLED _____

AGE M F _____

DATE OF BIRTH _____

ADDRESS _____

APT _____

CITY _____

STATE _____

ZIP _____

HOME PHONE _____

PATIENT'S SCHOOL _____

GRADE LEVEL _____

PATIENT'S HOBBIES/PETS _____

OTHER CHILDREN AND THEIR AGES _____

REFERRED TO OUR OFFICE BY (We wish to thank them) _____

PARENT'S MARITAL STATUS: MARRIED DIVORCED
 SEPARATED WIDOWED SINGLE

DENTAL HISTORY

YES NO

Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child? _____

Do you expect your child to be a cooperative patient? If no, please explain. _____

Do you have well water at home?

Does your child take fluoride tablets or vitamins with fluoride?

Has your child bumped any teeth? If so, when? _____

Has your child had a history of headaches, pain, popping or clicking of the jaws?

Does your child still have a night time bottle?

Does your child have a toothache?

Does your child have or has he or she had any of the following problems or habits?

____Thumb Sucking How Long?____ Still Active Y N

____Finger Habit How Long?____ Still Active Y N

____Pacifier How Long?____ Still Active Y N

Reason for initial visit: Cosmetic Emergency Decay
 Habit Behavior Physical or mental handicap
 Orthodontics Other, Please specify _____

MEDICAL HISTORY

• Is your child presently under the care of your family physician for any medical reason? Yes No If yes, what? _____

FAMILY PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

• Is your child in good health? If no, what? _____ Yes No

• Is your child under the care of a physician for other than routine care? If yes, explain. _____ Yes No

• Does your child have any drug allergies? If yes, explain. _____ Yes No

• Is your child taking any medications at this time? If yes, list. _____ Yes No

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? _____ Yes No

• Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. _____ Yes No

• Have your child's tonsils and/or adenoids been removed? Yes No

• Does your child breathe through the mouth? If yes Yes No
 () Seldom () Often

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

Allergy to Penicillin

Other drug allergy

Radiation treatment

Anemia

Rheumatic fever

Bone disorder

Mental handicap

Positive for H.I.V.

Diabetes

Epilepsy, seizures

Bleeding disorder

Heart Ailment or Murmur. Type, if known _____ Is child

under the care of a cardiologist or special physician for the

problem? If so, whom _____

Phone _____

Tuberculosis

Endocrine disorder

Physical handicap

Cleft palate

Asthma

Liver problems or hepatitis

Malignancies or leukemia

Speech problem

Hyperactivity

Attention Deficit Disorder

Please comment on any problems that were checked in the above areas

DO YOU CONSIDER YOUR CHILD TO BE:

Advanced in the learning process Yes No

Progressing normally Yes No

A slow learner Yes No

PREVENTIVE DENTAL HISTORY

How often does your child brush? _____

Is toothbrushing supervised? Yes No

By whom? _____

Is dental floss used? Yes No

Does your child receive:

Fluoride in vitamins Bottled water

Fluoride tablets/drops Well water

Fluoridated water

NEAREST RELATIVE / FRIEND

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

RELATIONSHIP _____

IN CASE YOU ARE NOT AT HOME, WHAT IS YOUR NEIGHBOR'S

NAME _____ PHONE _____

RESPONSIBLE PARTY FATHER / MOTHER

FATHER'S FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS# _____ BIRTH DATE _____

HOME PHONE # _____ BUSINESS PHONE # _____

EMPLOYER _____

OCCUPATION _____

DENTAL INSURANCE YES NO

INSURANCE COMPANY _____ GROUP OR PLAN NUMBER _____

INSURANCE COMPANY PHONE _____

MOTHER'S FULL NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SS# _____ BIRTH DATE _____

HOME PHONE # _____ BUSINESS PHONE # _____

EMPLOYER _____

OCCUPATION _____

DENTAL INSURANCE YES NO

INSURANCE COMPANY _____ GROUP OR PLAN NUMBER _____

INSURANCE COMPANY PHONE _____

FINANCIAL INFORMATION

Method of Payment: Please Check One

Check or cash at time of treatment

Visa, Mastercard, American Express or Discover

Insurance form with co-payment at time of treatment

Other: _____

- Payment is expected at time of treatment
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Dentistry for Children, PC, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNED (INSURED PERSON)

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for _____ (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE