DENTISTRY "4" CHILDREN PLLC

PATIENT INFORMATION

Full name____

Preferred name____

Sex M F Birthdate_______________________________________

Address____

City, State, Zip____

Phone__________________________

PARENT/GUARDIAN INFORMATION

FATHER____

Birthdate_______________ SSN___________________________

Employer____

Work Phone________________ Cell Phone___________________

MOTHER____

Birthdate_______________ SSN___________________________

Employer____

Work Phone________________ Cell Phone___________________

Marital Status **S M W SEP DIV**

Pager/message phone_____________________________________

Email____

LEGAL GUARDIAN (if other than parent)___________________

____

Address____

Employer____

Work Phone_________________ Home Phone_________________

Cell Phone___________________

EMERGENCY CONTACT________________________________

Phone______________________________

NEAREST RELATIVE NOT LIVING WITH YOU___________

__________________________ Phone________________________

ADDITIONAL INFORMATION

Have you been to this office with another child? If yes, name of child____

Reason for today's visit____________________________________

How did you hear about us?__________________________________

INSURANCE INFORMATION

Subscriber's name_______________________________________

Birthdate___________________ SSN________________________

Relationship to patient____________________________________

Name of insurance co.____________________________________

Group #__________________ Subscriber #___________________

If patient is covered by additional insurance, please complete below

Subscriber's name_______________________________________

Birthdate___________________ SSN________________________

Relationship to patient____________________________________

Name of insurance co.____________________________________

Group #__________________ Subscriber #___________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have the above named insurance coverage and assign directly to Dentistry ì 4î Children 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 dental office may use my healthcare 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 remain valid unless revoked in writing.

____

Signature of Parent or Guardian

____

Date

DENTAL HISTORY

Is this your child's first dental visit? Y N

If no, date of last dental exam________________________________

Dentist's name____

Were x-rays taken? Y N

Date & reason of last ***medical*** exam__________________________

____

Child's Physician____

City, State, Zip____

Phone____

Do you think your child will be a cooperative patient? Y N

Please indicate if your child has had any of the following:

	YES	NO
Toothaches		
Clenching or grinding teeth		
Lip sucking		
Cold sores (fever blisters)		
Mouth breathing		
Tooth abscess (gum boil)		
Stained teeth		
Bad breath		
Gum swelling or tenderness		
Bleeding gums		
Clicking/popping/pain in jaw		
Frequent sore throat		
Finger/thumb habit		
Pacifier use		
Presently nursing or drinking from a bottle		

If not, when did your child stop nursing or drinking from a bottle?
____

If nursing or drinking from a bottle, what are the usual contents?
____

If fluoride is taken, please indicate the source:

□ Water □ Toothpaste □ Pills □ Vitamins
□ Liquid rinse □ Gel □ Not taken

HEALTH HISTORY

MEDICATIONS

Please list any drugs or medications your child is taking at this time

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____

____

ALLERGIES

Please indicate if your child is allergic to or had an unfavorable reaction to any of the following:

- □ None
- □ Penicillin
- □ Amoxicillin
- □ Sulfa
- □ Latex
- □ Local Anesthetic
- □ Other known allergies to food or drug___________________

Please indicate if your child has had any of the following health problems:

	YES	NO
MRSA		
Asthma / hay fever		
Blood disorder		
Hemophilia		
Kidney problems		
Liver problems		
Growth problems		
Rheumatic fever		
Mental / emotional problems		
ADHD / ADD		
Heart murmur		
Heart problems		
Artificial heart valve(s)		
Sickle cell anemia		
Diabetes		
Breathing / lung problems		
Deafness / hearing loss		
Blindness / loss of sight		
Convulsions / seizures / epilepsy		
Tumors / cancer / leukemia		
Car / motion sickness		
Problems w/ concentrating		
Problems w/ learning		
Problems w/ speech		
Problems w/ cooperating		
Problems w/ understanding		
Other:		

If needed, please explain health problems______________________

____

____

____

____

My signature below indicates that I understand and have answered all questions to the best of my knowledge. I request and consent to the performance of any tests or procedures which are deemed necessary after a complete clinical examination. I understand it is my responsibility to provide and inform you with any insurance or health changes.

____
Signature of Parent or Guardian

Date __________________________