Welcome

Patient ID # _____ Today's Date _____

to our practice! 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 _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS# / SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Phone _____
Hobbies: _____ Pets: _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State/Prov. _____ Zip/P.C. _____
Email _____
SS#/SIN _____
DL# _____

Who is responsible for making appointments?

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____

Best time to call _____
Time _____ Days _____
_____

Mother

☐ Stepmother ☐ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father

☐ Stepfather ☐ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS#/SIN _____
DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS#/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/Prov. _____ Zip/P.C. _____
Deductible _____ Copay _____
Amount already used _____
Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check Credit Card ☐ Visa ☐ MC

☐ I wish to discuss the office's payment policy. ☐ _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Have you ever taken Fen-Phen/Redux?	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
5. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
6. Do you use tobacco?	☐	☐

8. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Seasonal Allergies	☐	☐
Food Allergies: _____		
Other (please list) _____		

9. Women Only:	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease / Trouble	☐	☐	Diabetes	☐	☐	Anxiety	☐	☐
Cardiac Pacemaker	☐	☐	Arthritis	☐	☐	ADHD	☐	☐
Heart Murmur	☐	☐	Joint Replacement / Implant	☐	☐	Autism	☐	☐
Mitral Valve Prolapse	☐	☐	Glaucoma	☐	☐	Developmental Disorders	☐	☐
Chest Pains	☐	☐	Kidney Disease	☐	☐	Learning / Communication Disorders	☐	☐
Heart Attack	☐	☐	Thyroid Problem	☐	☐	Eating Disorders	☐	☐
Angina	☐	☐	Stomach Troubles	☐	☐	Bulemia / Anorexia	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐	Mood Disorder	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Drug Abuse	☐	☐
Stroke	☐	☐	Radiation Therapy	☐	☐	Alcohol Abuse	☐	☐
Respiratory Problems	☐	☐	Chemotherapy	☐	☐	Previous Drug Rehabilitation	☐	☐
Rheumatic Fever	☐	☐	Sexually Transmitted Disease	☐	☐	TMJ Pain	☐	☐
Frequent / Persistent Cough	☐	☐	AIDS / HIV Infection	☐	☐	Swollen Ankles	☐	☐
Asthma	☐	☐	Epilepsy / Convulsions	☐	☐	Leukemia	☐	☐
Emphysema	☐	☐	Fainting / Seizures	☐	☐	Anemia	☐	☐
Tuberculosis	☐	☐	Dementia / Alzheimers	☐	☐	Other _____	☐	☐
Hepatitis / Jaundice	☐	☐	Vertigo	☐	☐			

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you feel pain to any of your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Do you have frequent headaches?	☐	☐
6. Do you clench or grind your teeth?	☐	☐

	Yes	No
7. Have you ever had any difficult extractions in the past?	☐	☐
8. Have you ever had any prolonged bleeding following extractions?	☐	☐
9. Have you had any orthodontic treatment? Who? _____	☐	☐

Current Medication List

	Yes	No
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? _____

_____

_____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental 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 dependents.

X _____

Signature of patient (or parent/guardian if minor) Date