Welcome!

Proper dental hygiene begins at an early age.
Please take a few minutes to provide us with the following
Information so that we may better care for your child's dental needs.

Patient and Family Information

Child's Name _____ Birthdate _____ ☐ Male ☐ Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address (if different from above) _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address (if different from above) _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____

Office Phone _____ Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

Has your child had any unfavorable experiences in a dental or medical office? ☐ Yes ☐ No

If so, please describe _____

How did you hear about us? ☐ Pediatrician/Physician ☐ Google ☐ Social Media ☐ Signage ☐ Word of Mouth

If referred, whom may we thank for doing so? _____

Child's Health History

Please check all that apply to your child:

☐ ADD/ADHD	☐ Diabetes	☐ Hepatitis – Type_____	☐ Tuberculosis
☐ Anemia	☐ Epilepsy	☐ Rheumatic Fever	☐ Other_____
☐ Asthma	☐ HIV/AIDS	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Murmer	☐ Tonsillitis	_____

Has your child had any unfavorable reactions to drugs, including antibiotics and local anesthetic solution? ☐ Yes ☐ No

If so, please specify _____

Has your child been diagnosed with allergies to any drugs, foods, or other products? ☐ Yes ☐ No

If so, please specify _____

Primary Dental Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____

Social Security # _____ Home Phone _____

Address (if different from above) _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or suppliuer of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____