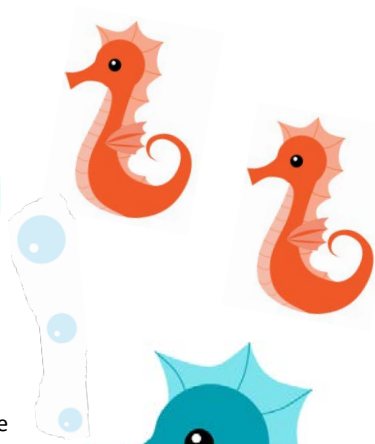




Welcome!
 Proper dental hygiene begins at an early age.
 Please take a few minutes to provide us with the following
 information so that we may better care for your child's dental needs.



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

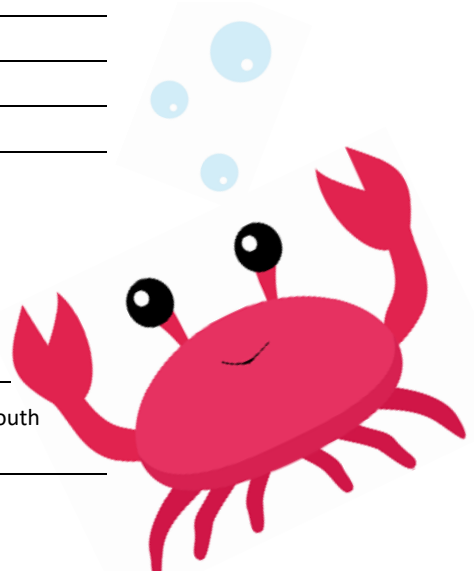
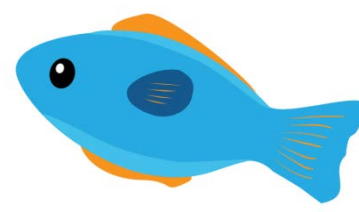
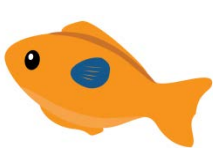
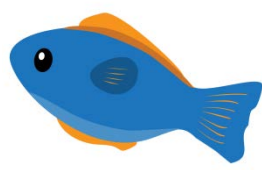
Former Dentist _____
 Office Phone _____ Date of last dental visit _____
 How often does your child brush? _____
 How often does your child floss? _____

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:

- | | | | |
|-----------------------------------|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis – Type _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> 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 supplier 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 _____

