WELCOME

WE WOULD LIKE TO WELCOME YOU AND YOUR CHILD TO OUR OFFICE. OUR GOAL IS TO MAKE EVERY CHILD'S VISIT PLEASANT AND EDUCATIONAL. OUR PRACTICE IS BASED ON PREVENTIVE CARE. WE STRIVE TO TEACH GOOD ORAL CARE THAT WILL ENABLE YOUR CHILD TO HAVE A BEAUTIFUL SMILE THAT LASTS A LIFETIME.

1. TELL US ABOUT YOUR CHILD:

TODAY'S DATE:_______/_______/_______

CHILD'S NAME________________________________ NICKNAME ________________

CHILD'S ADDRESS: ____

CITY:________________________ STATE:_______ ZIP:__________ PHONE: ______________

CHILD'S BIRTHDATE:_______/_______/_______ CHILD'S AGE__________ MALE_______ FEMALE__________

CHILD'S SSN # ____

2. WHO IS ACCOMPANYING THE CHILD TODAY?

NAME:________________________________ RELATIONSHIP:________________

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? YES / NO

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

OTHER FAMILY MEMBERS SEEN BY US: ______________________________

PARENT'S MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / SEPARATED

3. MOTHER'S INFORMATION: (STEP-MOTHER____/GUARDIAN____)

NAME:__________________________ EMPLOYER: ______________________

WORK #__________________ EXT:_______ HOME #________________ SSN ______________

CELL PHONE__________________________ E-MAIL ______________________

FATHER'S INFORMATION: (STEP-FATHER____/GUARDIAN____)

NAME:__________________________ EMPLOYER: ______________________

WORK #__________________ EXT:_______ HOME #________________ SSN ______________

CELL PHONE__________________________ E-MAIL ______________________

4. PERSON RESPONSIBLE FOR ACCOUNT:

NAME__________________________ RELATION TO PT:____________________

SSN #________________________________ BIRTHDATE:_______/_______/_______

BILLING ADDRESS: ____

CITY:________________________ STATE:_______ ZIP:__________ PHONE: ______________

CELL PHONE__________________________ E-MAIL ______________________

EMPLOYER________________________________ PHONE ________________

5. PRIMARY DENTAL INSURANCE:

INSURANCE CO. NAME: ____________________

INSURANCE CO. PHONE: ____________________ GROUP # ____________________

INSURED'S NAME____________________ RELATIONSHIP ____________________

INSURED'S BIRTHDATE:_____/_____/_____ & SSN ____________________

INSURED'S EMPLOYER:____________________ PHONE #____________________

SECONDARY DENTAL INSURANCE:

INSURANCE CO. NAME: ____________________

INSURANCE CO. PHONE: ____________________ GROUP # ____________________

INSURED'S NAME____________________ RELATIONSHIP ____________________

INSURED'S BIRTHDATE:_____/_____/_____ & SSN ____________________

INSURED'S EMPLOYER:____________________ PHONE #____________________

6. CHILD'S MEDICAL HISTORY:

CHILD'S PHYSCIAN: ____________________ PHONE: ____________________

PLEASE DESCRIBE THE CHILD'S CURRENT HEALTH: (CIRCLE ONE) GOOD / FAIR / POOR

PLEASE LIST ALL DRUGS THAT THE CHILD IS TAKING: ____________________

____

PLEASE LIST ALL DRUGS THAT THE CHILD IS ALLERGIC TO: ____________________

____

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS: (CIRCLE ANY THAT APPLY)

HEART MURMUR / CANCER / DIABETES / RHEUMATIC FEVER / HIV+ / AIDS / HEMOPHILIA / ASTHMA
HEPATITIS / TB / CONGENITAL HEART DEFECT / CONVULSIONS / EPILEPSY / ABNORMAL BLEEDING
OPERATIONS / OTHER____________________

7. I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBLITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I ALSO AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CLAIM. I HEREBY AUTHORIZE PAYMENT OF MY GROUP INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, TO THE DENTIST LISTED ON THIS FORM.

____

SIGNATURE OF PARENT OR GUARDIAN DATE

____

SIGNATURE (INSURED) DATE