

Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can 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 _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

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
- Lip or Cheek Biting
- Fingernail Biting
- Jaw Difficulty: Clicking and/or Pain
- Grinding Teeth

Child's Health History

Please check all that apply to your child:

- Allergies
- Anemia
- Asthma
- Cancer
- Diabetes
- Epilepsy
- HIV/AIDS
- Heart Murmur
- Hepatitis - Type _____
- Rheumatic Fever
- Scarlet Fever
- Tonsillitis
- Tuberculosis
- Other _____

Primary Dental Insurance

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
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 _____

