



Tell Us About Your Child

Today's Date: _____ Child's Name: _____ Nickname: _____

Child's Birthdate: ___/___/___ Child's Age: ___ Male Female Social Security #: _____

School: _____ Grade: ___ Other family members seen here: _____

Child's Home Address: _____
Street City State Zip

Child's Home Phone #: () _____

Parent's Information

Parent's Marital Status: Single Married Other

Mother DOB: ___/___/___ Hm Phone #: _____ Wk Phone #: _____ Cell #: _____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____

Father DOB: ___/___/___ Hm Phone #: _____ Wk Phone #: _____ Cell #: _____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____

Dental Insurance Information

Primary Insurance Company Name: _____ Phone #: () _____ Group/Policy #: _____

Company Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: ___/___/___ SS #: _____ Insured's Employer: _____

Employer's Address: _____
Street City TX Zip

Secondary Insurance Company Name: _____ Phone #: () _____ Group/Policy #: _____

Company Address: _____
PO Box/Street City State Zip

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: ___/___/___ SS #: _____ Insured's Employer: _____

Employer's Address: _____
Street City TX Zip

Medical History

Child's Physician: _____ Phone #: () _____ Date of last visit: _____

Address: _____
Street City State Zip

Child currently under the care of a physician? Yes No Please explain: _____

Your child's current physical health: Good Fair Poor Are Immunizations Current? Yes No

Please list all CURRENT MEDICATIONS: _____

Please list all DRUG ALLERGIES: _____

Other things that cause the child allergic reactions? _____

Anything you would like to discuss with the doctor in private? Yes No

Has the child had/experienced any of the following?

- | | | | |
|--------------------------------------------------|---------------------------------------------------|--------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Aids / HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Monocucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hospitalizations / Operations | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Handicaps / Disabilities | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mitral Valve Prolapse | |

Has the child experienced problems with previous dental work? Yes No

Any serious medical problems your child experiences? _____

Authorization

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have read the preceding conditions of treatment and payment and agree to their content.

I affirm this information is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize this office to perform the necessary services my child needs. .

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

