



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:

<input type="checkbox"/> Thumb/Finger Sucking	<input type="checkbox"/> Fingernail Biting	<input type="checkbox"/> Grinding Teeth
<input type="checkbox"/> Lip or Cheek Biting	<input type="checkbox"/> Jaw Difficulty: Clicking and/or Pain	

Child's Health History

Please check all that apply to your child:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis - Type _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever	



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 _____

