CHILD HEALTH/DENTAL HISTORY

ABOUT YOUR CHILD

Today's Date: _____

Childs Name: _____ _____ _____ Gender: F or M Birth date: _____
Last First Middle

_____ _____ _____ _____ _____
Address APT# City State ZIP Code

Home Phone: _____ Parent cell: (MOM) _____ (DAD) _____

DENTAL AND MEDICAL HISTORY INFORMATION

Date of your child's last dental examination: _____ Dentist Name: _____

Reason for today's dental visit: _____

Has your child had trouble from previous dental care? **Y** **N** If Yes, Explain_____

How will your child react during today's dental visit? _____

Has there ever been any type of local anesthetic administered to your child? **Y** **N**

Is your child experiencing any pain or sensitivity in his/her mouth or teeth? **Y** **N** If yes, where? _____

Does your child breathe through their mouth? **Y** **N** Have they ever had tongue thrust? **Y** **N**

Does your child suck his thumb/fingers? **Y** **N** Does your child have frequent bottle use/sleep with a bottle at night? Y N

Is your child currently under the care of physician? **Y** **N** If yes, why? _____

Name of child's physician: _____ Phone: _____

Please list any medications your child is currently taking: _____

Please list any serious medical problems that your child has/had: _____

Please list all drugs/medications your child is allergic to: _____

Has your child had any of the following medical problems? Please circle Y (yes) or N (no) to each of the following questions.

Anemia	**Y**	**N**	Allergies to Drugs	**Y**	**N**	Abnormal Bleeding	**Y**	**N**	Asthma	**Y**	**N**
Cancer	**Y**	**N**	Congenital Heart Disease	**Y**	**N**	Diabetes	**Y**	**N**	Epilepsy	**Y**	**N**
Heart Murmur	**Y**	**N**	Hearing Impairment	**Y**	**N**	Handicap / Disability	**Y**	**N**	Hemophilia	**Y**	**N**
HIV / AID	**Y**	**N**	Hospital Admission	**Y**	**N**	Seizure Disorder	**Y**	**N**	Rheumatic Fever	**Y**	**N**

I certify that I have read and understand the above questions.

Signature of person completing form: _____ Relationship to patient: _____

PARENT INFORMATION

Mother's name: _____ Phone: _____

Date of birth: _____ Employer: _____ Work phone: _____

Father's name: _____ Phone: _____

Date of birth: _____ Employer: _____ Work phone: _____

Parent marital status: Married _____ Single _____ Divorced _____ Widowed _____

DENTAL INSURANCE INFORMATION

Name of person insured _____ Relationship to patient _____

Insured person's birth date _____ Social security#_____

Insured's employer _____

Insurance co. name _____ Group # _____ Policy/ID# _____

Insurance co. address _____

City/State _____ ZIP _____ Phone _____

CONSENT FOR SERVICES

I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

X_____ _____ **Date**_____
Signature **Relationship to patient**

The **financial responsibility** of each patient must be determined before treatment. I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance claims and assist in making collections from the insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by Insurance Company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute or legal proceedings with respect to amounts owed by me for services rendered, the prevailing parting in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys fees. 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 have read the above conditions and agree to their content**.

X_____ **Date**_____
Signature

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, our policy is to charge for missed appointments at the rate of $50 per each appointment. Scheduled appointments requiring 1 or more hours will be charged at the rate of $100. Please help us serve you better by keeping scheduled appointments.

X_____ **Date**_____
Signature