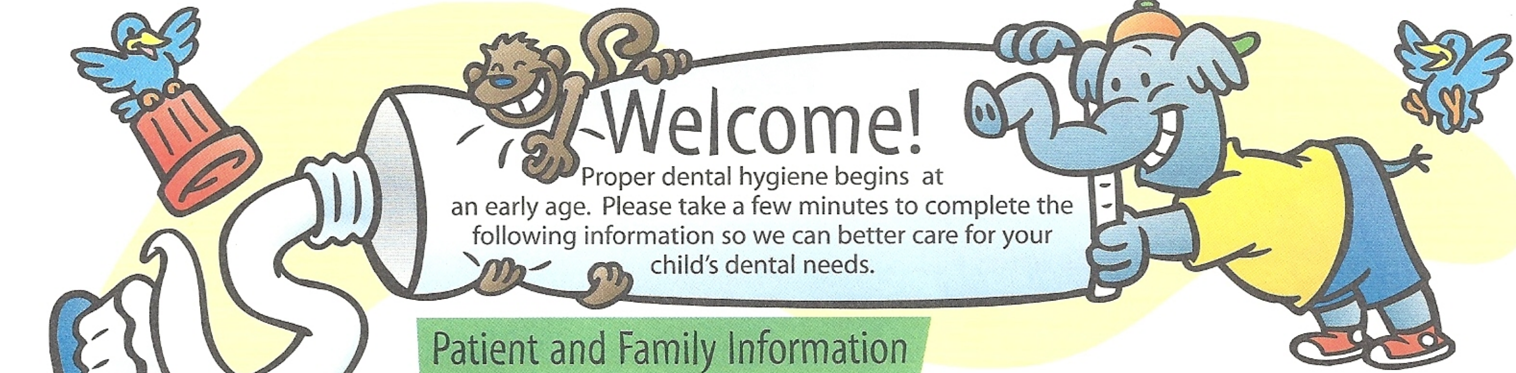

Welcome!

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 ______________________

Cell Phone ______________________ E-mail ______________________

Name of Father/Guardian ______________________ Birthdate __________

Social Security # ______________________ Home Phone ______________________

Address ____

City ______________________ State __________ Zip __________

Employer ______________________ Business Phone ______________________

Cell Phone ______________________ E-mail ______________________

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

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type ______ ☐ Tuberculosis
☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other ______________
☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever ______________
☐ Cancer ☐ Heart Murmur ☐ Tonsillitis ______________

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 ______________