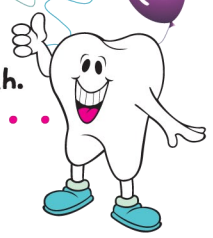
# W.E.L.C.O.M.E.

We are pleased to welcome you and your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your child's dental health.



## PATIENT INFORMATION

DATE _____ SS / HIC / PATIENT ID # _____ BIRTH DATE _____

NAME OF MINOR / CHILD _____ SEX ☐ M ☐ F AGE _____

NICKNAME _____ HOBBIES _____ CELL PHONE ( ) _____

HOME ADDRESS _____
STREET CITY STATE ZIP

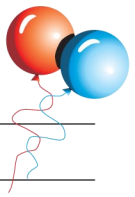
MAILING ADDRESS _____
STREET CITY STATE ZIP

SCHOOL NAME _____ SCHOOL PHONE ( ) _____

PERSON FINANCIALLY RESPONSIBLE _____ HOME PHONE ( ) _____ WORK PHONE ( ) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

## INSURANCE



FATHER'S / GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

HOME PH ( ) _____ WORK PH ( ) _____
(if different fromabove) (if different from above)

EMAIL _____

EMPLOYER _____

SS # _____ BIRTH DATE _____

Do you have dental insurance coverage for minor/child? ☐ YES ☐ NO

PLAN NAME _____ PHONE ( ) _____

ADDRESS _____

GROUP # _____ POLICY # _____

MOTHER'S / GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

HOME PH ( ) _____ WORK PH ( ) _____
(if different fromabove) (if different from above)

EMAIL _____

EMPLOYER _____

SS # _____ BIRTH DATE _____

Do you have dental insurance coverage for minor/child? ☐ YES ☐ NO

PLAN NAME _____ PHONE ( ) _____

ADDRESS _____

GROUP # _____ POLICY # _____

IS your child eligible for treatment under medical assistance? ☐ YES ☐ NO CHILD'S MEDICAL ASSISTANCE ID # _____

## DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST _____ FOR WHAT SERVICE? _____

| | | | |
|---|---|---|---|
| Has child complained about dental problems? | ☐ YES ☐ NO | Is fluoride taken in any form? | ☐ YES ☐ NO |
| Does child brush teeth daily? | ☐ YES ☐ NO | Any injuries to mouth, teeth, head? | ☐ YES ☐ NO |
| Does child use floss everyday? | ☐ YES ☐ NO | Any unhappy dental experiences? | ☐ YES ☐ NO |

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ YES ☐ NO

- OVER -

## MEDICAL HISTORY

MINOR /CHILD'S PHYSICIAN _____ CITY / STATE _____ PHONE ( )

DATE OF LAST PHYSICAL EXAMINATION _____ RESULTS _____

| | | |
|---|---|---|
| Is minor/child under care of physician now? | ☐ YES ☐ NO | MEDICATIONS |
| Receiving any medication or drugs? | ☐ YES ☐ NO | |
| Ever been hospitalized? | ☐ YES ☐ NO | |
| Ever had surgery? | ☐ YES ☐ NO | |
| Is there excessive bleeding when cut? | ☐ YES ☐ NO | ALLERGIES |

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

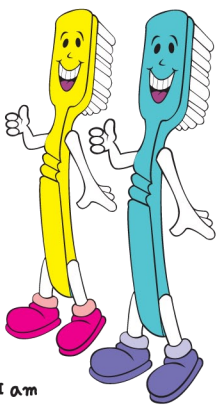
| | | | | |
|---|---|---|---|---|
| ☐ AIDS / HIV | ☐ Cerebral Palsy | ☐ Epilepsy | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Chicken Pox | ☐ Fainting | ☐ Liver Disease | ☐ Sinus Problems |
| ☐ Asthma | ☐ Convulsions | ☐ Hearing Problems | ☐ Measles | ☐ Thyroid Disease |
| ☐ Bladder Problems | ☐ Diabetes | ☐ Heart Problems | ☐ Mononucleosis | ☐ Tuberculosis |
| ☐ Cancer | ☐ Drug/Alcohol Abuse | ☐ Hepatitis | ☐ Mumps | ☐ Other |

## EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ PHONE ( )

NAME _____ RELATIONSHIP _____ PHONE ( )

## AUTHORIZATIONS



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

### MINOR / CHILD CONSENT

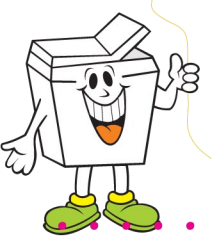
I am the parent, guardian, or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

### INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my minor/child's health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature of Parent, Guardian or Personal Representative _____ Date _____

Please print name of Parent, Guardian or Personal Representative _____ Relationship to Patient _____



## UPDATE (to be filled in at future appointments)

Has there been any change in patient's health since last dental appointment? ☐ YES ☐ NO

If yes, please describe _____

Is patient taking any new medications? ☐ YES ☐ NO If yes, please list _____

DATE _____ PARENT / GUARDIAN SIGNATURE _____

DATE _____ DENTIST SIGNATURE _____