Welcome

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 any questions we'll be glad to help you.
We look forward to working with you in maintaining your child's dental health.

adult & pediatric

Dental Studio

"The best smiles start here.."

PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____
FIRST NAME LAST NAME

BIRTHDATE: _____ NICK NAME: _____ SEX : M / F AGE: _____

FAVORITE: PET_____ TV SHOW _____ HOBBY _____

HOME ADDRESS: _____
STREET CITY STATE ZIP

NAME & AGES OF SIBLINGS: _____

SCHOOL NAME: _____ GRADE: _____

RESPONSIBLE PARTY: _____
RELATIONSHIP TO CHILD PHONE NUMBER

WHOM MAY WE THANK FOR REFERRING YOU? _____

PARENTS MARITAL STATUS : MARRIED___ SINGLE ___ WIDOWED ___ DIVORCED ___ PARTNERS ____

FAMILY INFORMATION

FATHER/ GUARDIAN'S NAME _____

ADDRESS:

_____

_____

HOME PHONE: _____ WORK PHONE: _____

OCCUPATION: _____ CELL PHONE: _____

EMPLOYER : _____

SOCIAL SECURITY: _____ BIRTHDATE : _____

MOTHER/ GUARDIAN'S NAME _____

ADDRESS:

_____

_____

HOME PHONE: _____ WORK PHONE: _____

OCCUPATION: _____ CELL PHONE: _____

EMPLOYER : _____

SOCIAL SECURITY: _____ BIRTHDATE : _____

INSURANCE

DO YOU HAVE DENTAL COVERAGE: YES ____ NO____

PLAN NAME: _____

PHONE: _____

GROUP NUMBER: _____ POLICY NUMBER:_____

DO YOU HAVE DENTAL COVERAGE: YES ____ NO____

PLAN NAME: _____

PHONE: _____

GROUP NUMBER: _____ POLICY NUMBER:_____

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

NAME OF PREVIOUS DENTIST _____ LAST SET OF X-RAYS TAKEN _____
HAS CHILD COMPLAINED ABOUT DENTAL PROBLEMS: YES____ NO____
IS FLUORIDE TAKEN IN ANY FORM: YES___ NO____ HOW? _____ DOES CHILD BRUSH DAILY? YES ____ NO_____ HOW MANY TIMES ___

ANY INJURIES TO MOUTH, TEETH, HEAD? YES_____ NO_____ WHAT? _____
DO YOU ASSIST YOUR CHILD WITH BRUSHING? YES ____ NO _____ FLOSSING? YES ____ NO _____
ANY UNHAPPY DENTAL EXPERIENCES? YES ___ NO ____ WHAT? _____

ANY MOUTH HABITS - THUMBSUCKING, MOUTH BREATHING, PACIFIER, SLEEPING WITH A BOTTLE, GRINDING? _____

MEDICAL HISTORY

CHILD'S PHYSICIAN: _____ ADDRESS: _____ PHONE: _____
DATE OF LAST PHYSICAL EXAMINATION : _____ RESULTS: _____

IS CHILD UNDER CARE OF PHYSICIAN NOW? YES____ NO ____ IF YES, WHY? _____
RECEIVING ANY MEDICATION OR DRUGS? YES ___ NO____ IF YES, WHAT? _____
EVER BEEN HOSPITALIZED? YES___ NO ____ IF YES, WHY? _____
EVERY HAD SURGERY? YES ___ NO___ IF YES, WHAT? _____

ALLERGIES? PENICILLIN _____ LATEX _____ LOCAL ANESTHETICS _____ ASPIRIN _____ NUTS _____ FOODS _____ OTHER? _____

WOULD YOU LIKE TO TALK PRIVATELY TO THE DENTIST ABOUT ANY HEALTH ISSUES? YES ____ NO____

HAS YOUR CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK THE FOLLOWING:

- ___ ADD/ ADHD
- ___ ANEMIA
- ___ ASTHMA
- ___ AUTISUM
- ___ BLADDER/KIDNEY PROBLEMS
- ___ EXCESSIVE BLEEDING
- ___ BLOOD DISORDERS
- ___ CANCER
- ___ CEREBRAL PALSY
- ___ CLEFT LIP/ PALATE
- ___ DEVELOPMENTAL DELAYS
- ___ DIABETES
- ___ DRUG/ALCOHOL ABUSE
- ___ EPILEPSY
- ___ FAINTING
- ___ HEARING PROBLEMS
- ___ HEART PROBLEMS
- ___ HEPATITIS
- ___ HIV/AIDS
- ___ KIDNEY DISEASE
- ___ LIVER DISEASE
- ___ RHEUMATIC FEVER
- ___ SEIZURES
- ___ SENSORY ISSUES
- ___ SINUS PROBLEMS
- ___ SPEECH PROBLEMS
- ___ THYROID DISEASE
- ___ TUBERCULOSIS

OTHER _____

PERINATAL/ BEHAVIORAL HISTORY

CHILD WAS BORN AT HOW MANY WEEKS GESTATION? _____ DESCRIBE: _____
ANY PROBLEMS OR COMPLICATIONS DURING PREGNANCY/DELIVERY? YES__ NO__ _____
DOES YOUR CHILD HAVE ANY EMOTIONAL OR BEHAVIORAL PROBLEMS? YES__ NO__ _____
DOES YOUR CHILD HAVE ANY SENSITIVITIES TO SOUND, TASTE, ETC.? YES__ NO__ _____
DO YOU ANTICIPATE YOUR CHILD HAVING DIFFICULTIES ACCEPTING DENTAL TREATMENT? YES__ NO__
EXPLAIN: _____

AUTHORIZATION

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 REPRESNTATIVE OF

_____
PLEASE PRINT NAME OF CHILD

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 NAMES 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 IS COVERED BY INSURANCE WITH _____
NAME OF INSURANCE COMPANY(IES)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ADULT & PEDIATRIC DENTAL STUDIO FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I DO NOT PAY THE ENTIRE NEW BALANCE WITHIN 25 DAYS OF THE MONTHLY BILLING DATE, A LATE CHARGE ON THE BALANCE OWED WILL BE ASSESSED EACH MONTH. IN THE CASE OF DEFAULT OF PAYMENT OF THIS ACCOUNT, I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS AMOUNT OR ANY FUTURE OUTSTANDING ACCOUNT BALANCES. I UNDERSTAND THAT MY DENTAL INSURANCE MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICE. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OF MY DEPENDANTS. I AUTHORIZE THE ABOVE PROVIDER OF SERVICES TO RELEASE INFORMATION REQUIRED TO RECURE THE PAYMENT OF BENEFITS. PAYMENT IS DUE AT THE TIME OF SERVICE. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE _____

DATE _____