# PLEASE COMPLETE THE ENTIRE FORM

**DATE:** _____

**PATIENT INFORMATION**

Patients Legal Name: _____ Nick Name: _____ Birth Date: _____ Patients Age: _____

Patients Address: _____City: _____State: _____ Zip: _____Male: __ Female: __

Who referred you to our office: _____

**PARENT OR GUARDIAN INFORMATION**

Mothers Name: _____ Birth Date: _____ Mothers SSN: _____

Mothers Address: _____City: _____State: _____ Zip: _____Marital Status: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with mother: yes: ___ no: ___ E-mail Address: _____

Fathers Name: _____ Birth Date: _____ Fathers SSN: _____

Fathers Address: _____City: _____State: _____ Zip: _____ Marital Status: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with Father: yes: ___ no: ___ E-mail Address: _____

EMERGENCY CONTACT NOT IN THE HOME: _____ Cell: _____ Home: _____

**If you are Legal Guardian accompanying patient, please give a copy of guardianship papers to the front desk and fill the above section out. Whom may we NOT discuss treatment with regarding this patient: _____**

**PRIMARY DENTAL INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED**

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

**SECONDARY INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED**

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

**I give Dentistry for Children permission to use Nitrous Oxide (laughing gas) and/or local anesthetic as needed to treat this patient. _____ yes _____ no**

_____ _____

Signature of Parent or Guardian Date

**I give Dentistry for Children permission to take necessary diagnostic films to properly make a complete diagnosis for treatment. _____ yes _____ no**

_____ _____

Signature of Parent or Guardian Date

**I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the patients' medical status. I authorize the dental staff to perform the necessary dental services for this patient.**

_____ _____

Signature of Parent or Guardian Date

**PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY, INCLUDE DATES AND SPECIFICS ABOUT A CONDITION. THIS INFORMATION WILL HELP OUR STAFF TREAT THE PATIENT COMPLETELY.**

**PATIENT NAME_____ DOB_____M/F_____ WEIGHT_____**

**PROBLEMS AT BIRTH: ___ NONE**
___ Complications before or during birth, ___ Premature,___ birth defects, ___inherited conditions,___ growth and development issues
**Explain**_____

**CARDIAC: ____NONE**
___ Congenital heart defect, heart murmur ___Irregular heartbeat/palpitations, high blood pressure ___Abnormal ECHO
___ Premedication needed **Explain:** _____
_____

**EAR, NOSE, THROAT: _____NONE**
__Snoring, sleep apnea, excessive gagging ___Recent strep throat or respiratory infection ___Exposure to tobacco
___Impaired hearing, vision or speech **Explain**: _____
_____

**PULMONARY: _____NONE**
____ Asthma, reactive airway, breathing problems ___Recent bronchitis/pneumonia, RSV, croup___ Narrow airway
____Cystic fibrosis, tuberculosis **Explain**: _____
_____

**GI/GU: ____ NONE**
___ Acid reflux, GERD, stomach ulcer, intestinal problems, ___Hiatal hernia ___Hepatitis, jaundice ___Kidney or liver transplant, bladder problems ___Prolonged diarrhea, vomiting ____ Lactose or food intolerance **Explain**:_____
_____

**NEUROLOGIC: ____NONE**
__Seizures/epilepsy, cerebral palsy, brain injury __ Syncope/dizziness __Muscle paralysis or weakness __Recurrent or frequent headaches, fainting ____ Concussion **Explain**: _____
_____

**MUSCULOSKELETAL: ____ NONE**
___Arthritis, scoliosis, muscle joint problems ___ Neck movement problems __Muscular dystrophy, __low muscle tone ___ Fractures
**Explain**_____

**PSYCHOSOCIAL: ____NONE**
___Development disorders, learning delays ___ADD___ADHD ___Autism
**Explain**_____

**ENDOCRINE/METABOLIC: _____NONE**
___Diabetes, hyperglycemia, hypoglycemia ___Thyroid/pituitary ___Adrenal disorder ___Metabolic syndrome ___Precocious puberty or hormonal problems ___Growth Hormones **Explain:** _____
_____

**BLOOD DISORDERS: ____ NONE**
___Anemia _____ Sickle Cell ___ Bleeding disorder, Easy bleeding or bruising ___Leukemia ____ Transfusion ___Cancer, tumor, chemotherapy, radiation, bone marrow transplant **Explain:** _____
_____

**OTHER: ___NONE**
___Down syndrome _____ Pierre-Robin syndrome **Explain**: _____
___Hunters syndrome _____ Hurlers syndrome _____

**PLEASE FILL OUT THE BACK SIDE ALSO**

**PLEASE LIST YOUR PRIMARY CARE DOCTOR AND ANY OTHER SPECIALISTS YOUR CHILD SEES:**

**NAME** **PHONE NUMBER** **REASON**

_____

_____

**PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING: Dose and Reason**

---

**IS YOUR CHILD ALLERGIC TO ANY FOODS, MEDICATIONS, ANESTHESIA, LATEX, and DYES OR METALS: If yes, please list.**

_____

**THIS CHILD IS CURRENT ON ALL THEIR IMMUNIZATIONS: ___YES ___NO. If no, please explain why.**

---

**Has there been any significant changes or disruptions in the patient's family, home or school routine? Yes___ No___ If yes please explain: _____**

**Is there anything about the patient's family medical or dental history we should be aware of? ___NO ___YES Explain_____**

**PATIENT ORAL HEALTH:**

How would you describe the patient's?

Oral Health: Good:_____Fair:_____Poor:_____ Eating Habits: Good:____Fair:_____Poor:_____

Snacking Habits: Healthy: _____Mostly Sweet:_____ More than 2 times a day_____1 time a day or less____

Breath: Normal:_____Odor:_____ Sucking habits after age 1: thumb:_____Fingers_____Pacifer:_____

How often do you or the patient brush their teeth_____ Floss _____?

Does the patient participate in any sports_____ If so is a mouth guard worn_____

Has your child been treated by another dentist_____ If yes date of last visit_____ Reason for visit_____

X-rays taken _____.

Has your child had any tooth pain or mouth injury since their last visit? Yes____ No_____ If yes please explain_____

Is there anything else we should know or concerns you have, before treating your child? _____ if yes please explain_____

---

**I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the patients' medical status. I authorize the dental staff to perform the necessary dental services for this patient.**

_____

Signature of Parent or Guardian Relationship Date

Initial Dr._____ Initial Staff_____

# DENTISTRY FOR CHILDREN
# FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office, and to let you know we are committed to providing your family with the best possible care. So there is no misunderstanding as to what our financial policy is, please take time to read and sign this form. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We reserve the right as the doctor to change treatment as deemed necessary, for the benefit of the patient.

We strive to inform our families of treatment costs prior to services being performed, however should your family require emergency care after hours, weekends or holidays there will be an additional fee that may not be covered by your insurance.

We understand not everyone has access to dental insurance, therefore we offer several ways to take care of your families fees. We offer Care Credit, and accept cash, checks, and most major credit cards. For those families who have dental benefits we will file your claim as a courtesy, provided you supply us with the assignment of benefits and correct insurance information. If this information is not supplied prior to the appointment you will be required to pay for the services that day. In order to continue to deliver a high quality of care to our patients, any patient balance will be due day of service.

Your insurance is a contract between you and the insurance company. Payment to us is your responsibility. Please keep in mind that not all services are covered benefits on all plans and the term **Reasonable and Customary** fee for dental care varies greatly between insurance companies.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account. From time to time we are faced with families not responding to our help in payment of their bills, for these cases we do use an outside collection agency. After 90 days an 18% finance charge is assessed. If we have to file suit to recover the dental fees, the undersigned shall be responsible for reasonable attorney fees, and interest charges from the attorney fees incurred, to collect the past due amount. We reserve the right to contact the credit bureau if necessary.

If we should receive a returned check from your bank you will be notified and expected to pay your bill with cash or credit card with in two weeks. If you do not respond nor take care of your outstanding balance within one month we will not be able to continue to see the family in our practice. We will make several attempts to reach you regarding the matter but it is your responsibility to take care of the returned check.

So there is no misunderstanding as to what our financial expectations are please read the information carefully and then sign. You may request a copy.

---

Parent or Guardian Signature