WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill our 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.

Date_____ SS/HIC/Patient ID #_____ Birthdate _____

Name of Minor _____ Sex M F Age_____

Nickname_____ Hobbies _____ Cell (___) _____

Home Address _____

Mailing Address_____

School Name_____ School Phone (___)_____

Person Financially Responsible_____ Home Phone(___)_____

Work Phone(___)_____Whom may we thank for referring you?_____

Insurance

Father's Name_____

Address (if different from above)_____

Home(___)_____Work (___)_____

E-Mail_____

Employer_____

SS#_____Birthdate_____

Do you have dental insurance coverage for minor/child Y/N

Plan Name_____Phone(___)_____

Mother's Name_____

Address (if different from above)_____

Home(___)_____Work (___)_____

E-Mail_____

Employer_____

SS#_____Birthdate_____

Do you have dental insurance coverage for minor/child Y/N

Plan Name_____Phone(___)_____

Dental History

Date of last visit to a dentist_____

Has child complained about dental problems

Does child brush teeth daily……Y/N

Does child use floss every day……Y/N

Mouth habits- thumb sucking……Y/N

Nail biting, mouth breathing, pacifier….Y/N

For what service?_____

Is fluoride taken in any form?.....Y/N

Any injuries to mouth, teeth, head?.....Y/N

Any unhappy dental experiences?.....Y/N

Does your child sleep with a bottle…….Y/N

Medical History

Minor/Child's Physician_____City/State_____Phone(___)_____

Date of last physical examination_____ Results_____

Is minor/ child under care of physician?	Y/N	Medications_____
Receiving any medications or drugs?	Y/N	_____
Ever been hospitalized?	Y/N	_____
Ever had surgery?	Y/N	Allergies_____
Is there excessive bleeding when cut?	Y/N	_____

Has child had any history of or difficulty with any of the following? (Please circle)

A.I.D.S./ H.I.V	Cerebral Palsy	Epilepsy	Kidney Disease	Rheumatic fever
Anemia	Chicken Pox	Fainting	Liver Disease	Sinus Problems
Asthma	Convulsions	Hearing	Measles	Thyroid Disease
Bladder	Diabetes	Heart	Mononucleosis	Tuberculosis
Cancer	Drug/Alcohol	Hepatitis	Mumps	other _____

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone(___)_____

Name_____ Relationship_____ Phone(___)_____

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.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____ and assign directly to Dr. Brown all insurance benefits, if any, otherwise payable to me for services entered. 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 benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Minor/Child Consent

I am the legal parent, guardian or personal representative of this child. 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.

Guardian Signature_____ Date_____

Print Name _____Relationship Patient_____