Why have you brought your child to visit us today? _____

Is this your childs first visit to the dentist? _____

Has your child ever had a serious problem with a previous dental treatment? (If so, please explain)

Please circle Y for Yes and N for No

Y N Does your child suck his/her thumb or pacifier?

Y N Does your child take fluoride drops, tablets or rinse?

Child's Medical Health

Your child's physician _____ Phone _____

Has your child ever been hospitalized? (If so, please give reason)

Is your child allergic to: **Please circle Y for Yes and N for No**

Y N Local injected anesthetics (Novocaine)
Y N Penicillin
Y N Latex, Metals, Plastics
Y N Aspirin
Y N Codeine
Y N Sulfites/Sulfides
Other_____

Has your child ever been treated for: **Please circle Y for Yes and N for No**

Y N Asthma
Y N Bleeding disorder
Y N Diabetes
Y N Arthritis
Y N Hearing loss
Y N Heart disease
Y N Heart murmur
Y N Joint replacement or artificial prosthesis
Y N Fainting spells
Y N Prolonged bleeding
Y N Hepatitis
Y N Emotional problems
Y N Rheumatic fever
Y N Seizures
Y N Lung disease/TB

Has your child had any serious illness not listed above? **Y N** If yes please explain _____

_____

Is their anything else you would like us to know about your child? _____

Medications

Does your child usually take an antibiotic prior to a dental treatment? _____

List all medications your child is currently taking (or has recently taken) and the condition for which they are prescribed:

Medication _____ Dosage _____ Condition _____

Medication _____ Dosage _____ Condition _____

Medication _____ Dosage _____ Condition _____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name of nearest relative not living with child _____ Phone _____

Medical health reviewed by:

X _____
Doctor's Signature

X _____
Doctor's Signature

X _____
Doctor's Signature

If Patient is a minor:

X _____
Parent/Guardian's Signature

X _____
Parent/Guardian's Signature

X _____
Parent/Guardian's Signature

Power of Attorney

I, the undersigned, hereby authorize _____

to bring in _____ to receive dental treatment.

Signature of Parent or Guardian X _____ Date _____

I give my permission for this Office to administer any necessary treatment in the event of a medical emergency.

Signature of Parent or Guardian X _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

Child's Name	Age ☐ M ☐ F	Birthdate / /
Home Address	City, State, Zip	Social Security Number
Who will normally accompany your child to the appointment?	Phone	Child's Home Phone
Father's Name Phone	Mothers Name	Phone
Email Address		Cell Phone
Preference of Payment ☐ Cash/Check on day of treatment ☐ Major Credit Card	Do You Have: Dental Benefits? ☐ Y ☐ N Dual Benefits? ☐ Y ☐ N Medical Benefits? ☐ Y ☐ N	*(Please provide us with your benefit card(s))*

Person Responsible to Pay for Services	☐ Self ☐ Parent ☐ Spouse *(Relationship to Patient)*	
Name	Social Security Number - -	Home Phone ( )
Home Address	City, State, Zip	Birthdate / /
Email Address		Cell Phone ( )
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	☐ M ☐ F	Drivers License#
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City, State, Zip	Length Employed Yrs. Mos.

Spouses Name	Spouses Social Security Number	Birthdate / /
Spouses Employer	Spouses Occupation	Spouses Work Phone ( )
Spouses Business Address	City, State, Zip	Length Employed Yrs. Mos.

How did you hear about this Office?

(check only one)

☐ Referral a by friend ☐ Yellow Pages ☐ Relative ☐ Insurance Plan ☐ Welcome Wagon

☐ Radio Ad ☐ TV Ad ☐ Newspaper Ad ☐ Direct Mailing ☐ Sign by Building

Who selected this Office ☐ Self ☐ Spouse ☐ Parent ☐ Employer

Where did you find the Phone Number to this Office? _____

If you were referred, whom may we thank for referring you? _____

Terms and Conditions

This Office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination.

I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions and agree to their content.

Signed _____ **Date** _____