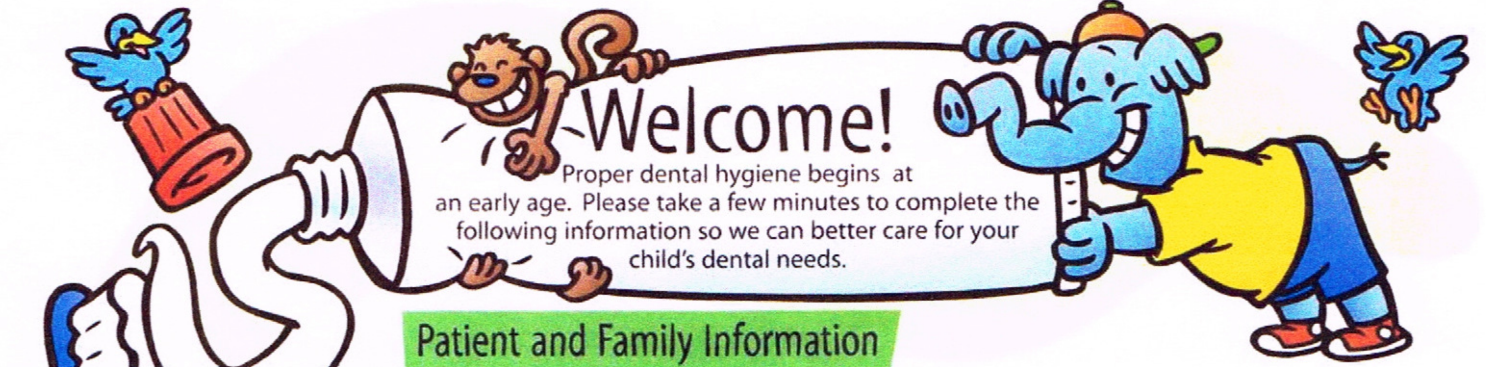

Patient and Family Information

Child's Name ________________ Birthdate ________ ☐Male ☐Female

Social Security # ________________ Home Phone ________________

Home Address ________________________________

City ________________ State ________ Zip ________

School ________________ Grade ________

Responsible Party ________________________________

Relationship to Child ________________________________

Name of Mother/Guardian ________________ Birthdate ________________

Social Security # ________________ Home Phone ________________

Address ________________________________

City ________________ State ________ Zip ________

Employer ________________ Business Phone ________________

Cell Phone ________________ E-mail ________________

Name of Father/Guardian ________________ Birthdate ________________

Social Security # ________________ Home Phone ________________

Address ________________________________

City ________________ State ________ Zip ________

Employer ________________ Business Phone ________________

Cell Phone ________________ E-mail ________________

Child's Dental History

Former Dentist ________________ Office Phone ________________

Address ________________________________

City ________________ State ________ Zip ________

Date of last dental visit ________________________________

How often does your child brush? ________________________________

How often does your child floss? ________________________________

Please check all that apply to your child:

☐ Thumb/Finger Sucking ☐ Fingernail Biting ☐ Grinding Teeth

☐ Lip or Cheek Biting ☐ Jaw Difficulty: Clicking and/or Pain

Child's Health History

Please check all that apply to your child:

☐ Allergies ☐ Diabetes ☐ Hepatitis – Type ______ ☐ Tuberculosis

☐ Anemia ☐ Epilepsy ☐ Rheumatic Fever ☐ Other ________________

☐ Asthma ☐ HIV/AIDS ☐ Scarlet Fever ________________

☐ Cancer ☐ Heart Murmur ☐ Tonsillitis ________________

Primary Dental Insurance

Person Responsible for Account ______________________________

Relationship to Patient ______________________ Birthdate ______________

Social Security # ______________________ Home Phone ______________

Address ______________________________

City ______________________ State ________ Zip ________

Employer ______________________ Business Phone ______________

Business Address ______________________ Occupation ______________

Insurance Company ______________________________

Insurance Company Address ______________________________

Subscriber I.D. # ______________________ Group # ______________

Additional Insurance

Person Responsible for Account ______________________________

Relationship to Patient ______________________ Birthdate ______________

Social Security # ______________________ Home Phone ______________

Address ______________________________

City ______________________ State ________ Zip ________

Employer ______________________ Business Phone ______________

Business Address ______________________ Occupation ______________

Insurance Company ______________________________

Insurance Company Address ______________________________

Subscriber I.D. # ______________________ Group # ______________

Assignment and Release

I hereby authorize payment directly to ______________________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________ Date ______________