



# Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

## 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
- Lip or Cheek Biting
- Fingernail Biting
- Jaw Difficulty: Clicking and/or Pain
- Grinding Teeth

## Child's Health History

Please check all that apply to your child:

- Allergies
- Anemia
- Asthma
- Cancer
- Diabetes
- Epilepsy
- HIV/AIDS
- Heart Murmur
- Hepatitis - Type \_\_\_\_\_
- Rheumatic Fever
- Scarlet Fever
- Tonsillitis
- Tuberculosis
- Other \_\_\_\_\_

## 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 \_\_\_\_\_

