

## WELCOME





١							
	About Your Child						
	Today's Date:/ File #:						
Child's Name:  LAST FIRST M Child's Nickname: Boy							
	School: Grade:						
	Child's Home Phone #:()						
2	Child's SS#:						
	Child's Address:						
1	HOME ADDRESS						
3	CITY STATE ZIP						
	Referred By:(If doctor, please give address & phone number.)						
	(ii doctor, please give address a priorie number.)						
١							
١	Insurance Information						
	Primary Dental Insurance						
	Co. Name:						
	Address:						
	CITY STATE ZIP						
-	Phone #:						
	Insured's ID#:						
	Group # (Plan, Local, or Policy #):						
	Insured's Name:						
1	Relation:Date of Birth://						
4	Insured's Employer:						
	Does either policy cover Orthodontics?  Yes No						
١	Secondary Dental Insurance						
۱	Co. Name:						
	Address:						
	CITY STATE ZIP						
	Phone #:						
	Insured's ID#:						
	Group # (Plan, Local, or Policy #):						
	Insured's Name:						
	Polation: Data of Pirth: / /						

Insured's Employer: \_

3		The state of the s				
3	Child's Fami	y Informa	ition			
Who is accompanying this	s child today?					
FULL NAME (IF OTHER THAN PARE						
Do you have Legal Custo						
How many Brothers/Siste  Mother's Name:	rs r Age(s)	•				
Mother's Name:	□ ST	EP MOTHER 🔲 GU	JARDIAN			
( CHECK IF SAME AS CHILD'S)						
() HOME PHONE #	() WORK PHONE #	EXT	:			
MOTHER'S SOCIAL SECURITY #						
Employer:		riow Long:				
EMPLOYER'S ADDRESS	CITY	STATE	ZIP			
Father's Name:	□ s	TEP FATHER GU	JARDIAN			
( CHECK IF SAME AS CHILD'S)						
()_ HOME PHONE #	_ ()					
FATHER'S SOCIAL SECURITY #						
Employer:	ā	How Long?				
EMPLOYER'S ADDRESS	CITY	STATE	ZIP			
			0			
4	Accoun	Informa	tion			
Person ultimately respons	THE RESERVOIS ASSESSMENT	TIME SWE				
Name:		DEL ATION TO SU				
Billing Address:		RELATION TO CH	HILD			
CITY	STATE/	ZIP	ř.			
SOCIAL SECURITY #	DATE OF BIRTH	DRIVERS LIC. #	+			
()_ WORK PHONE #:	EXT. CELL PHO	) DNE #:				
Payment method: 🔲 C	ash 🔲 Check					
☐ Credit Card - Enter card #	# above (if accepted)					
I hereby authorize	assignment of my in	surance rights a	ınd			
Initials benefits directly to understand I am solely response	the provider for serv	rices rendered.	I fully			
insurance company (if offered at this office).						



		5	4		51	
		5	Child's	s Dental	Information	
		Reason for today's visit: 🔲 Exan	n 🔲 Emergency	☐ Consulta	ition	-
	$((0))^{-}$	Is Child in pain? In No In Yes H				
		Please indicate <b>a</b> any of the follow Discomfort, clicking or popping		okon Filling(s)	Cl Stained tooth	
		Red, swollen or bleeding gums			Locking Jaw	
		Sensitive tooth, teeth or gums.	Ringing	in Ears	☐ Bad breath	
	7	Blisters/Sores in or around the	mouth.   Broken/	Chipped toot	h 🔲 Loose tooth	
	July 1	Other(s):  Does child require pre-medication	n? 🔲 Yes 🗀 No 🏻	Don't knov	v	
		Previous Dentist:		_ ()		
	رنخيًا	Last Dental exam://_	Last Dental >	⟨-rays: /	'	
C	The death of	Times a day child brushes?				
4		Is the child's water fluoridated?	The state of the s			
	5 14	How would you rate the child's sn	nile? Best 1 2 3	4 5 6 7	8 9 10 Worst	
/	C					
		Child	d's Medical H	listory		
3	Is Child taking any of the following me			Stimulants		
	☐ Blood Thinners ☐ Tranquilizers ☐ I	nsulin Muscle relaxers Others				
9	Child's Physician:		) PHONE#			
	ADDRESS CITY		edical Exam:/_	/		
	Does Child have or ever had any o	f the following diseases, medica	l conditions or pro N High/Low Blood Press	cedures?		
	Y N Rheumatic fever	N Respiratory Problems	N Hepatitis			
	Y N Congenital Heart defect	N Blood Transfusion(s)	N Artificial Bones/Joints N Liver/Kidney/Organ P	Strain Company of the		
			N HIV+/AIDS/ARC N Tuberculosis TB			7
			N Psychiatric Problems N Hyper Active/ADD		(1.	
	Y N Jaw Problems TMJ/TMD	N Cleft Lip/Palate	N Fainting/Seizures/Epi	epsy		
1	Y N Hearing Problems Y Please list any other medical condition		N Cerebral Palsy			
1		7.7		1	111 6	
7	Is Child allergic to: Latex Penic		Dental Anesthetics	(Novocaine)		
2	☐ Aspirin ☐ Food allergies ☐ Othe	97.70			_ <i>I</i>	1
11	Please rate the child's general health					
Has this child ever taken the drug Ritalin?  No Yes/How long? Child's Blood type: Does this child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking						
	☐ Heavy Snoring ☐ Mouth Breath		_ ronguo rimuoling	/ Cuoming	L	
		The state of the state of			7	
	We invite you to discuss with us any qu	uestions regarding our services. The bes	st Dental health service	es are based	UPDATE (OFFICE USE)	
	on a friendly, mutual understanding bety	veen provider and patient.			, ,	
		ccount is not paid within 90 days of th	e date of service and	no financial	Initials Date	
	arrangements have been made, you wi any other expenses incurred in collectin	charges and	Comments			
	I authorize the staff to perform any necessary provider to release any information requirements.	authorize the	Initials Date			
	I understand the above information and	guarantee this form was completed con	rectly to the best of m	y knowledge	Comments	
		inform this office of any changes to the i	a a a a a a a a a a a a a a a a a a a	laea.	Initials Date	S. Carlot
	SignatureParent	or Guardian	Pate/ /		Comments	1
				1 /		