PATIENT'S
NAME_____ Date_____Date of Birth_____
Last First Initial

IF CHILD:
PARENT'S NAME_____
Last First Initial

HOW DO YOU WISH
TO BE ADDRESSED_____
Single☐ Married☐ Separated☐ Widowed☐ Minor☐
RESIDENCE - STREET_____
CITY_____STATE_____ZIP_____
BUSINESS ADDRESS_____
TELEPHONE: RES._____BUS._____
PATIENT/PARENT EMPLOYED BY_____
PRESENT POSITION_____HOW LONG HELD____
SPOUSE/PARENT NAME_____
SPOUSE EMPLOYED BY_____
PRESENT POSITION_____HOW LONG HELD_____
WHO IS RESPONSIBLE FOR THIS ACCOUNT_____
METHOD OF PAYMENT: Insurance☐ Credit Card☐ Cash☐
PURPOSE OF CALL_____
OTHER FAMILY MEMBERS IN THIS PRACTICE_____
_____
WHOM MAY WE THANK FOR THIS REFERRAL_____
_____
PATIENT/PARENT SOCIAL SECURITY #_____
SPOUSE/PARENT SOCIAL SECURITY #_____
SOMEONE TO NOTIFY IN CASE OF AN EMERGENCY
NOT LIVING WITH YOU_____
_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____#YRS._____
NAME OF INSURANCE CO._____
ADDRESS_____
_____
TELEPHONE:_____
PROGRAM OR POLICY #_____
UNION OR LOCAL GROUP_____
SOCIAL SECURITY NO._____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME_____
EMPLOYEE DATE OF BIRTH_____
EMPLOYER_____#YRS._____
NAME OF INSURANCE CO._____
ADDRESS_____
_____
TELEPHONE:_____
PROGRAM OR POLICY #_____
UNION OR LOCAL GROUP_____
SOCIAL SECURITY NO._____

RELEASE:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____DATE_____

REGISTRATION

PATIENT'S NAME_____ _____/_____/_____

Last First Initial Date of Birth

PARENT'S NAME_____

Last First Initial

CIRCLE THE APPROPRIATE ANSWER

DENTAL HISTORY

1. Is this the child's first visit to a dentist?.....YES NO
2. If not, how long since the last visit to the dentist?_____
3. When was the last time the teeth were cleaned?_____
4. Were X-rays taken?.....YES NO
5. Does the child eat between meals?.....YES NO
6. Does the child eat sweets, such as candy, soda pop, chewing gum?.....YES NO
7. Does the child eat well-balanced meals?.....YES NO
8. Does the child brush teeth upon arising?.....YES NO
   - When going to bed?.....YES NO
   - Right after eating meals?.....YES NO
   - After eating any food?.....YES NO
9. Do you live in an area without fluoridated water?.....YES NO
10. Have teeth been treated with fluorides?.....YES NO
11. Have any cavities been noted in the past?.....YES NO
12. Were any teeth (baby or permanent) removed by extraction?.....YES NO
    - Was it suggested that the space be maintained?.....YES NO
    - Was appliance placed?.....YES NO
13. Have there been any injuries to teeth, such as falls, blows, chips, etc?.....YES NO
    If so, describe_____
14. Has the child had any unfavorable dental experiences?.....YES NO
15. How many children in your family?_____
16. Has anyone in the family, including parents, had orthodontics?.....YES NO
17. Has child ever received a local anesthetic or any form of anesthetic?.....YES NO
18. Has child ever had occlusal sealants?.....YES NO

MEDICAL HISTORY

1. Is child in good health?.....YES NO
2. Is child under care of physician?.....YES NO
   If yes, since when_____Why_____
   _____
3. Name of physician_____
4. Is child receiving any medication?.....YES NO
5. Has the child had any serious illness?.....YES NO
6. Is the child allergic to penicillin, antibiotics, or other drugs?.....YES NO
7. Does the child have any other allergies?.....YES NO
8. Has child had surgery?.....YES NO
9. Is surgery contemplated?.....YES NO
10. Is child subject to profuse bleeding?.....YES NO
11. Is child subject to nervous disorders?.....YES NO
    - Fainting?.....YES NO
    - Dizziness?.....YES NO
12. Has child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, toothache, ear infection.

COMMENTS

PRESENT MEDICATIONS

ALLERGIES (DRUGS OR OTHER)

OTHER EXPLANATIONS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE_____DATE_____

DENTIST'S SIGNATURE_____DATE_____

CHILD DENTAL MEDICAL HISTORY