Tell Us About Your Child

Today's Date: _______________ Child's Name: ___________________________________ Nickname: _____________

Child's Birthdate: ____/____/____ Child's Age: ____ Male ☐ Female ☐ Social Security #: ________________

School: __________________ Grade: ___ Other family members seen here: __________________________________

Child's Home Address: ____
Street City State Zip

Child's Home Phone #: (___)_______________

Parent's Information

Parent's Marital Status: Single ☐ Married ☐ Other ☐

Mother DOB: ____/____/____ Hm Phone #: _______________ Wk Phone #: _______________ Cell #: ____________

Name: ____ Social Security #: ______________

Address: ____
Street City State Zip

Employer: ____

Father DOB: ____/____/____ Hm Phone #: _______________ Wk Phone #: _______________ Cell #: ____________

Name: ____ Social Security #: _______________

Address: ____
Street City State Zip

Employer: ____

Dental Insurance Information

Primary Insurance Company Name: ______________________ Phone #: ( )_______ Group/Policy #: ___________

Company Address: ____
PO Box/Street City State Zip

Insured's Name: __________________________________ Relationship to Patient: ___________

Insured's DOB: ____/____/____ SS #: __________ Insured's Employer: __________________

Employer's Address: ____
Street City TX Zip

Secondary Insurance Company Name: ______________________ Phone #: ( )_______ Group/Policy #: ___________

Company Address: ____
PO Box/Street City State Zip

Insured's Name: ___________________________________ Relationship to Patient: ___________

Insured's DOB: ____/____/____ SS #: ___________ Insured's Employer: __________________

Employer's Address: ____
Street City TX Zip

Medical History

Child's Physician: ____________________________ Phone #: (___)________ Date of last visit:____________

Address: ____

Street City State Zip

Child currently under the care of a physician? ☐ Yes ☐ No Please explain: ________________________________

Your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all CURRENT MEDICATIONS:____

Please list all DRUG ALLERGIES:____

Other things that cause the child allergic reactions? ____

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following?

☐ Aids / HIV+
☐ Anemia
☐ Asthma
☐ Blood Transfusion
☐ Cancer
☐ Chicken Pox
☐ Congenital Heart Defect
☐ Convulsions
☐ Diabetes
☐ Epilepsy
☐ Handicaps / Disabilities
☐ Hearing Impairment
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Hives
☐ Hospitalizations / Operations
☐ Kidney Problems
☐ Liver Problems
☐ Low Blood Pressure
☐ Lupus
☐ Measles
☐ Mitral Valve Prolapse
☐ Monocucleosis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sickle Cell Anemia
☐ Skin Rash
☐ Tonsillitis
☐ Tuberculosis (TB)

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Any serious medical problems your child experiences? ____

Authorization

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay for said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have read the preceding conditions of treatment and payment and agree to their content.

I affirm this information is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize this office to perform the necessary services my child needs. .

____ Date: ____________ Relationship to Patient: ____________________

Signature of patient, parent or guardian

____ Date: ____________ Relationship to Patient: ____________________

Signature of guarantor of payment/responsible party