MINOR CHILD PATIENT INFORMATION

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CHILD INFORMATION

CHILD'S NAME		BIRTHDATE	AGE
NICKNAME		SEX	SS# /SIN
SCHOOL			GRADE
PRIMARY HOME ADDRESS		CITY/STATE/ZIP	
PRIMARY PHONE	CONTACT NAME		RELATIONSHIP TO CHILD

RESPONSIBLE PARTY

MOTHER'S NAME		☐ STEP MOTHER	☐ GUARDIAN
PRIMARY PHONE		HOME/WORK PHONE	
HOME ADDRESS	CITY/STATE/ZIP	EMAIL	
EMPLOYER	OCCUPATION	SS#/SIN	
DRIVER'S LICENSE #	STATE	D.O.B.	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED			
FATHER'S NAME		☐ STEP FATHER	☐ GUARDIAN
PRIMARY PHONE		HOME/WORK PHONE	
HOME ADDRESS	CITY/STATE/ZIP	EMAIL	
EMPLOYER	OCCUPATION	SS#/SIN	
DRIVER'S LICENSE #	STATE	D.O.B.	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED			

INSURANCE

NAME OF INSURED		RELATIONSHIP TO PATIENT	
BIRTHDATE	SS# / SIN	NAME OF EMPLOYER	UNION OR LOCAL #
EMPLOYER ADDRESS		CITY/STATE	WORK PHONE
INSURANCE COMPANY		GROUP #	POLICY I.D.#
INSURANCE COMPANY ADDRESS		CITY/STATE/ZIP	
HOW MUCH IS YOUR DEDUCTIBLE?		HOW MUCH HAVE YOU USED?	MAX. ANNUAL BENEFIT

NAME OF INSURED		RELATIONSHIP TO PATIENT	
BIRTHDATE	SS# / SIN	NAME OF EMPLOYER	DATE OF EMPLOYMENT
EMPLOYER ADDRESS		CITY/STATE	OCCUPATION
INSURANCE COMPANY		GROUP #	POLICY I.D.#
INSURANCE COMPANY ADDRESS		CITY/STATE/ZIP	

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT: ☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

PAYMENT IS REQUIRED IN FULL AT EACH APPOINTMENT.

CHILD'S NAME

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

	YES	NO		YES	NO
How often does your child brush?			How often does your child floss?		
Is your child's water fluoridated?	❑	❑	Does your child take fluoride supplements?	❑	❑
Does your child:					
Suck thumb/finger?	❑	❑	Grind his/her teeth	❑	❑
Suck/bite lip?	❑	❑	Clench jaws	❑	❑
Bite/Chew nails?	❑	❑	Gag easily	❑	❑
Chew hard objects? (pencils, etc)	❑	❑	Tonsils/Adenoids removed at age _____ years	❑	❑
Wet the bed?	❑	❑	Have a speech problem	❑	❑
Breathe mostly through his/her mouth?	❑	❑			
Previous Dentist Name:			Previous dentist's address		
Date of last dental visit:					
Has your child had difficulty with previous dental visits?					
Child's primary Physician/Pediatrician:			Doctor's Phone number:		
Previous hospitalizations/Surgeries/Serious Illness:				Date:	
				Date:	
				Date:	
Is your child currently taking medications?	❑	❑	Please list:		
Does your child have a history of allergies to any drugs? Penicillin, Novocain, etc?	❑	❑	Please list:		
Does your child have a history of allergies to any other substances? Latex, environmental,, etc?	❑	❑	Please list:		
Has your child ever had any of the following:					
Acid Reflux	❑	❑	Heart Problem	❑	❑
Anemia	❑	❑	Describe:		
Asthma	❑	❑	Hemophilia/Abnormal Bleeding	❑	❑
Cancer	❑	❑	Hepatitis	❑	❑
Convulsions/Epilepsy	❑	❑	HIV/AIDS	❑	❑
Diabetes	❑	❑	Persistent cough	❑	❑
Food Allergies	❑	❑	Rheumatic Fever	❑	❑
Handicap/Disabilities	❑	❑	Stomach, liver or kidney problems	❑	❑
Hearing Impairment	❑	❑	Tuberculosis	❑	❑

Please explain any medical condition that your child has:

I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in my child's medical status.

I authorize the staff to perform the necessary services that he/she might need.

I authorize the release of any information, including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services, and I agree to be responsobile for payment o fall services rendered on behalf of my child.

Signature of Parent/Guardian: Date:

Signature of Dentist: Date: