WELCOME

Today's Date: __________

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you to maintain your child's dental health.

PATIENT INFORMATION

Full name of Minor/Child: ____

Sex: ☐ M ☐ F Age: ________ Date of Birth: ________________ School: ____________________

Home Phone: ________________________ Hobbies: ____________________ ____________________

Home Address: ________________________ City: ______________ State: _______ Zip: ________

Mailing Address: ________________________ City: ______________ State: _______ Zip: ________

Person financially responsible: ________________________ Their phone number: ____________________

Whom may we thank for referring you? ____

INSURANCE

Mother/Guardian's Name: ______________________

Address (if different from patients): ______________

____

Home phone (if different): ____________________

Work phone: ______________________________

Employer: ________________________________

SS #: ________________ Date of birth: __________

Do you have dental insurance coverage for this child?

Yes____ No____

Plan name: ______________________________

Insurance Phone #: ________________________

Insurance Address: ________________________

____

Group #: ______________ Policy #: ____________

Father/Guardian's Name: ______________________

Address (if different from patient's): ______________

____

Home phone (if different): ____________________

Work phone: ______________________________

Employer: ________________________________

SS #: ________________ Date of birth: __________

Do you have dental insurance coverage for this child?

Yes____ No____

Plan name: ______________________________

Insurance Phone #: ________________________

Insurance Address: ________________________

____

Group #: ______________ Policy #: ____________

DENTAL HISTORY

In the event of an emergency, whom should we contact? (please list two)

Name: __________________________ Relationship: ________________ Phone: ________________

Name: __________________________ Relationship: ________________ Phone: ________________

DENTAL HISTORY

Previous Dentist: ____________________ Phone #: ______________ Date of last visit: ______________

Has child complained about dental problems? . . . . Y N

Does child brush teeth daily? . . . . Y N

Does child use floss every day? . . . . Y N

Is fluoride taken in any form? . . . . Y N

Any injuries to mouth, teeth, head? . . . . Y N

Any unhappy dental experiences? . . . . Y N

Any mouth habits? Thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? . . . . Y N

Notes: ____

____

MEDICAL HISTORY

Minor/Child's Physician: ____________________ City/State: ______________ Phone: ______________

Date of last physical examination: ______________ Results: ______________________________

Is Minor/Child under the care of a physician now? . . . Y N

Receiving any medications or drugs? . . . . Y N

Ever been hospitalized? . . . . Y N

Ever had surgery? . . . . Y N

Is there excessive bleeding when cut? . . . . Y N

Medications: ______________________________

____

____

Allergies: ______________________________

____

Has minor/child had any history of or difficulty with any of the following? If yes, please circle

A.I.D.S./H.I.V.	Cerebral Palsy	Epilepsy	Kidney Disease	Rheumatic Fever
Anemia	Chicken Pox	Fainting	Liver Disease	Sinus Problems
Asthma	Convulsions	Hearing Problems	Measles	Thyroid Disease
Bladder Problems	Diabetes	Heart Problems	Mononucleosis	Tuberculosis
Cancer	Drug/Alcohol Abuse	Hepatitis	Mumps	Other

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian ______________________________ Date ______________

I certify that my minor/child is covered by insurance with (name of insurance company) ______________________________

and assign directly to Dr. Bae all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian ______________________________ Date______________