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Welcome to our office! Please fill out this form completely in ink.

Child's name _____ Birthdate _____ Sex F M
Last First MI

Child's Social Security # _____ Name child goes by _____

Child's Home Address _____

City _____ St _____ Zip _____ Phone # _____

Grade _____ Names of children in family _____

Do parents live together? ___ Yes ___ No If not, with whom does the child live? _____

Emergency Contact: _____ Phone: _____

Parent or Guardian Information _____ **Mother** _____ **Stepmother** _____ **Guardian**

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone # _____

SS# _____ Pager# _____ Cell# _____

Marital Status _____ Email Address _____

Parent or Guardian Information _____ **Father** _____ **Stepfather** _____ **Guardian**

Name _____ DOB _____ Occupation _____
Last First MI

Employer _____ Work Phone # _____

SS# _____ Pager# _____ Cell# _____

Marital Status _____ Email Address _____

Who told you about our office? _____

Who is your family dentist? _____

Method of Payment

___ Check or cash at time of treatment ___ Bank Card ___ Credit Card
___ Insurance – Plus co-payment at time of treatment ___ Care Credit ___ ARKids

Primary Dental Insurance

Insured's name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Phone # _____

Secondary Dental Insurance

Insured's name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer _____

Insurance Co. _____ Group # _____

Insurance Co. Phone # _____

Financial Policy

Fees for dental services rendered are due on the date of treatment. Our office, as a courtesy to you, will file for insurance benefits for treatment rendered. You will be responsible for any deductibles, co-payments or balances not covered by your insurance. All account balances which have not been paid within 30 days become the responsibility of the parent/guardian. There will be a \$25.00 charge on all returned checks.

CHILD'S MEDICAL AND DENTAL HISTORY

Name of child's pediatrician or physician _____

Has your child been hospitalized since birth? Yes No If yes, explain _____

Is your child allergic to any medicine or foods? Yes No If yes, explain _____

Is your child presently taking any medication? Yes No If yes, explain _____

Has your child ever had any of the following:

NO	YES		NO	YES	
_____	_____	Autism	_____	_____	Blood Disease
_____	_____	Asthma	_____	_____	Cancer/Tumors
_____	_____	Hepatitis	_____	_____	Stomach/Kidney Problems
_____	_____	Abnormal Bleeding	_____	_____	Liver Problems
_____	_____	Diabetes	_____	_____	Convulsions/Epilepsy
_____	_____	Handicap/Disabilities	_____	_____	HIV/AIDS
_____	_____	Tuberculosis	_____	_____	Ear Problems
_____	_____	Skin Disorder	_____	_____	Tubes in ears
_____	_____	Rheumatic Fever	_____	_____	Speech/Vision Problems
_____	_____	Heart Condition	_____	_____	Hyperactivity/ADD/ADHD
_____	_____	Premedication needed	_____	_____	Mental/Emotional Disorder
_____	_____	Lung Disorder	_____	_____	Latex Allergy
_____	_____	Nose/Throat Disorder	_____	_____	Other

Please explain any medical problems that your child has: _____

Is this your child's first visit to the dentist? Yes No

If not, please give date of last dental care: _____ Previous Dentist: _____

Is your child on a bottle? Yes No If no, at what age was it discontinued? _____

Is your child a thumb/finger sucker or ever used a pacifier? Yes No Age discontinued _____

Is your primary source of water from a well? Yes No

Has your child had any type of injury to his/her teeth? Yes No

If yes, please explain: _____

Has your child had any problems with previous dental treatment? Yes No

If yes, please explain: _____

Is your child in dental pain today? Yes No

If yes, please explain: _____

Does your child have a dental condition about which you are especially concerned? Yes No

If yes, please explain: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian _____ Date _____