



## PATIENT INFORMATION

Mr.  Mrs.  Ms.  Dr.       Male  Female       Single  Married  Divorced  Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number	Drivers Licence Number		Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

## PERSON RESPONSIBLE FOR ACCOUNT Check here if same as above

Mr.  Mrs.  Ms.  Dr.       Male  Female       Single  Married  Divorced  Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number	Drivers Licence Number		Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

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Turn Page Over

## INSURANCE INFORMATION

Check here if you do not have Dental Insurance

Check here if you previously provided information

Insured's First & Last Name	Date of Birth	Social Security	
Name of Insured's Employer		Patient Relationship to Insured	
Insurance Company	Phone	Subscriber ID#	Group ID#
Insurance Company Address	City	State	Zip

\*A 3.95% processing fee is added to any credit card transaction.

## REFERRAL INFORMATION

**How did you first hear about our office?**  Another patient (relative)  Another patient (friend)  New patient flyer  Yahoo  
 Another dental or medical office  School  Work  Church  Drive by office  Google  Yelp  Yellow pages  
 Employee  Community/charity event  Insurance company  Health/benefits fair or event

If you were referred to us by someone, please write their name \_\_\_\_\_



## CHILD HEALTH/DENTAL HISTORY FORM

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address  <small>CITY STATE ZIP CODE</small>					
Phone  <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
<b>Has the child had any history of, or conditions related to, any of the following:</b>					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> General Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other_____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
<b>Please list the name and phone number off the child's physician:</b>					
Name of Physician _____			Phone _____		

### Child's History

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time?.....<br>If yes, please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the child ever been hospitalized?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has that child ever received a general anesthetic?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the child ever had a blood transfusion?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is the child physically, mentally, or emotionally impaired?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the child experience excessive bleeding when cut?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child had any problem with dental treatment in the past?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has the child ever suffered any injuries to the mouth, head, or teeth?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the child had any orthodontic treatment?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. What type of water does your child drink?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Is fluoride toothpaste used?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does the child participate in active recreational activities?.....  | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date



## CONSENT FOR TREATMENT

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I authorize the doctor and designated team members to gather the information necessary to make a thorough diagnosis of my dental needs. In general, diagnostics include radiographs, study models, periodontal measurements, photographs and/or other aids deemed appropriate by the doctor to make an accurate diagnosis. Radiographs are required to complete your examination, diagnosis, and treatment plan.

I understand there are risks involved in receiving dental treatment, as well as risks involved in choosing not to obtain the treatment recommended. I understand that I can ask for a complete recital of any possible complications.

The treatment specifically recommended for you will be explained to you in detail. It can include, but is not limited to, the following:

- Dental Cleanings (above the gum line)
- Periodontal Treatment (below the gum line)
- Fillings
- Crowns, Bridges, Veneers
- Implants
- Tooth Extractions
- Orthodontics
- Root Canal Therapy
- Temporomandibular Joint Dysfunction
- Sleep Apnea

I understand during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I give my permission to make any changes and additions as necessary.

I understand that I have the right to choose on the basis of adequate information, from alternative treatment plans that meet the doctor's professional standard of care. It is important to provide your dentist with an accurate medical history before, during, and after treatment. It is equally important to follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled follow-up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read each paragraph above and consent to recommended treatment as needed.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date