PATIENT INFORMATION
DATE:_____

Child's full name:_____ Nickname:_____
Child's birth date:_____ Age:_____ ___Male ___Female SS#_____
Address_____City/State _____Zip_____
Home Phone_____ Whom may we thank for referring you_____
Names of other children _____

GUARDIAN INFORMATION

Mother: (Guardian / Stepmom) _____ Birthdate: _____ Marital Status _____
Address (If different from child) _____
Home Phone _____ Work Phone_____ Cell Phone _____
Employer_____ Occupation _____
Dental Insurance Carrier _____ S.S.# _____

Father: (Guardian / Stepdad) _____ Birthdate: _____ __Marital Status _____
Address (If different from child) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____
Dental Insurance Carrier _____ S.S.#_____

MEDICAL HISTORY

Child's Physician_____ Phone _____
Does you child have any medical/developmental problems?_____
Does your child have any emotional problems?_____
Is your child taking any medications?_____
Is your child allergic to any medications or food?_____
Has your child ever been diagnosed with a heart murmur?_____
Circle any that apply: Cerebral Palsy / Convulsions / Diabetes / Down's Syndrome / Epilepsy / Hepatitis / HIV

DENTAL HISTORY

What is the reason for this visit?_____
Is this your child's first visit to any dentist?_____ If not, when was last visit?_____
Has your child ever had dental x-rays?_____ By Whom_____
Has your child ever used a pacifier? No_____ Yes_____ Still Does_____ Age when stopped_____
Has your child ever sucked a finger? No_____ Yes_____ Still Does_____ Age when stopped_____
Age when child taken off bottle_____ Child's interests, hobbies, etc._____

CONSENT

Because _____ is a minor, signed permission must be obtained from a parent or guardian before any dental services can be rendered. I give my consent to the performance of such treatments, services, medications, operations, and local anesthesia necessary to treat any dental deficiency, abnormality, or infection. I further understand that none of the above-mentioned procedures will be rendered without first obtaining my approval.

Signed:_____ **Date:**_____ **Relationship to child:**_____

FINANCIAL

I understand that I am responsible for all charges incurred in this office, except for Medicaid eligible procedures. A service charge of $5.00 per billing cycle, or 1.5% per month, 18% APR, whichever is greater, will be added to all overdue accounts, as well as all legal and collection fees. A $25.00 service charge will be added to all NSF checks.

Signed:_____ **Date:**_____