CHILDREN'S DENTAL CENTER

Date ___ /___ / _____

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Name ______________________________ Nickname __________
Last Name First Name Middle Initial

Address ______________ City ____________ State ______ Zip ________

Home Phone ____________ Cell Phone ____________ DOB ____ / ____ / ______

Social Security # ________-______-________ Sex: ☐ M ☐ F

Grade __________ School/Daycare ______________________________

Names/ages of other children in family: ______________________________

How did you hear about us?

☐ Radio ☐ Television ☐ Insurance
☐ Internet ☐ Personal reference ☐ Walk-in
☐ Phonebook ☐ Local event __________ ☐ Other __________

In case of emergency who should we contact? ______________ Phone __________

Person responsible for account ______________________________

Primary Dental Insurance

Primary insured's information only required below

Name ______________________________
Last Name First Name Middle Initial

Relationship to patient ______________ DOB _____ / _____ / ______

Social Security # ________-______-________ Contact Number ______________

Address ______________ City ____________ State ______ Zip ________

Email address ______________ Employer ______________

Insurance Company ______________ Phone ______________

Subscriber ID # ______________ Group # ______________

Medicaid ID # ______________ Carrier: TMHP / DentaQuest / MCNA Dental

CHIP ID # ______________ Carrier: TMHP / DentaQuest / MCNA Dental

Guardian Signature ______________________________ Date ___ /___ / _____

HEALTH HISTORY

YOUR CHILD'S OVERALL HEALTH AS WELL AS ANY MEDICATIONS WHICH YOUR CHILD TAKES COULD HAVE AN IMPORTANT ROLE WITH THE DENTAL CARE HE/SHE RECEIVES. PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY AND COMPLETELY:

HAS YOUR CHILD BEEN TO THE DENTIST BEFORE? ☐ YES ☐ NO HOW WOULD YOU RATE YOUR CHILD'S EXPERIENCE AT THE PREVIOUS DENTIST'S OFFICE? ☐ GOOD ☐ BAD

HOW OFTEN DOES YOUR CHILD BRUSH THEIR TEETH? ______________________ FLOSS? ______________________

DOES YOUR CHILD TAKE FLUORIDE SUPPLEMENTS? ______________________

PLEASE MARK "YES" OR "NO" FOR THE FOLLOWING QUESTIONS REGARDING YOUR CHILD:

YES	NO		YES	NO	
☐	☐	SUCKS FINGER/THUMB	☐	☐	CHEWS ON HARD OBJECTS (PENCILS, ETC.)
☐	☐	SUCKS/BITES LIP	☐	☐	GRINDS TEETH
☐	☐	BITES/CHEWS NAILS	☐	☐	CLENCHES JAWS

PLEASE MARK BELOW IF APPLICABLE:

☐ HEART DISEASE/MURMUR	☐ BLEEDING/TRANSFUSIONS	☐ ASTHMA	☐ BLOOD DYSCRASIAS
☐ LIVER/GI DISEASE	☐ ANEMIA	☐ DIABETES	☐ HIV/AIDS
☐ KIDNEY DISEASE	☐ RHEUMATIC FEVER	☐ HEPATITIS	☐ MENTAL DELAYS
☐ SPEECH/HEARING PROBLEMS	☐ SEIZURES	☐ CLEFT LIP/PALATE	☐ PHYSICAL DELAYS
☐ CEREBRAL PALSY	☐ CONGENITAL BIRTH DEFECTS	☐ PERSONALITY/SOCIAL	☐ OTHER PROBLEMS ____________
☐ CANCER/TUMORS	☐ RECURRENT HEADACHES	☐ FREQUENT INFECTIONS	______________________

PLEASE EXPLAIN ANY ITEMS CHECKED ABOVE: ____

PLEASE LIST ANY MEDICATIONS YOUR CHILD TAKES: ____

____

PLEASE LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES/ILLNESSES: ____

CHILD'S PRIMARY DOCTOR: ______________________ PHONE NUMBER: ______________________

IS YOUR CHILD ALLERGIC TO LATEX OR ANY MEDICATIONS? ☐ YES ☐ NO IF SO, PLEASE LIST: ____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. ____________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ____ Date _______ / _______ / _________