



# Welcome!

Proper dental hygiene begins at an early age. Please take a few minutes to complete the following information so we can better care for your child's dental needs.

## Patient and Family Information

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  Male  Female  
 Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Responsible Party \_\_\_\_\_  
 Relationship to Child \_\_\_\_\_  
 Name of Mother/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Name of Father/Guardian \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

## Child's Dental History

Former Dentist \_\_\_\_\_ Office Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of last dental visit \_\_\_\_\_  
 How often does your child brush? \_\_\_\_\_  
 How often does your child floss? \_\_\_\_\_  
 Please check all that apply to your child:  
 Thumb/Finger Sucking       Fingernail Biting       Grinding Teeth  
 Lip or Cheek Biting       Jaw Difficulty: Clicking and/or Pain

## Child's Health History

Please check all that apply to your child:  
 Allergies       Diabetes       Hepatitis - Type \_\_\_\_\_       Tuberculosis  
 Anemia       Epilepsy       Rheumatic Fever       Other \_\_\_\_\_  
 Asthma       HIV/AIDS       Scarlet Fever      \_\_\_\_\_  
 Cancer       Heart Murmur       Tonsillitis      \_\_\_\_\_



## Primary Dental Insurance

Person Responsible for Account \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## Additional Insurance

Person Responsible for Account \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
Subscriber I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

## Assignment and Release

I hereby authorize payment directly to \_\_\_\_\_  
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 the  
information required to secure the payment of benefits. I authorize the use of this signature on all  
insurance submissions.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

