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 ____________