

**Welcome To Treasured Smiles Pediatric Dentistry**

**Patient Forms**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST M.I.

Patients Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ □ M □ F

Child’s School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

Child’s Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Does your child have or ever had any of the following medical conditions? **Y N** Heart Murmur | **Y N** Tonsillitis | **Y N** High/low blood pressure |
| **Y N** Rheumatic fever | **Y N** Respiratory problems | **Y N** Hepatitis |
| **Y N** Artificial Heart Valves | **Y N** Asthma | **Y N** Artificial Bones/Joints |
| **Y N** Congenital Heart defect | **Y N** Blood Transfusion | **Y N** Organ Problems |
| **Y N** Scarlet Fever | **Y N** Leukemia/Anemia | **Y N** HIV/AIDS/ARC |
| **Y N** Surgeries/Operations | **Y N** Diabetes/hypoglycemia | **Y N** Tuberculosis TB |
| **Y N** Cancer/Tumors | **Y N** Hemophilia | **Y N** Psychiatric Problems/Autism |
| **Y N** Chemotherapy | **Y N** Abnormal bleeding | **Y N** Hyperactive ADD |
| **Y N** Jaw problem TMJ/TMD | **Y N** Cleft lip/palate | **Y N** Fainting/seizures/epilepsy |
| **Y N** Hearing problem | **Y N** Birth defects | **Y N** Cerebral Palsy |

Please list any other medical condition(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Child taking any of the following medications? Pain Killers□ (including ASPIRIN) □ Ritalin □ Asthma Medication □ Insulin □ others □:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies to: Latex □ Penicillin□ Amoxicillin□ Tetracycline □ Novocain □ Aspirin□ Food allergies□ Others□ :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this Child ever taken the drug Ritalin? No□ Yes□ /How long?\_\_\_\_\_\_\_\_\_\_\_

Are your child’s Immunizations up to date? No□ Yes□

**Dental History**

Last Dental Visit \_\_/\_\_/\_\_\_\_

Dental Concerns:

Thumb sucking Tongue Sucking □ Nail Biting□ Grinding of teeth □ Bottle usage □

Pacifier □

Fluoride toothpaste: **Y N**

How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Who is accompanying this child today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

**PLEASE INCLUDE AT LEAST 2 CONTACT NUMBERS**

Do have legal Custody of this child? Yes□ No □

**Mother’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Guardian

Mother’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CHECK IF SAME AS CHILD’S) Street City State Zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Social Security Number\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Mother’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Guardian

Father’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(□ CHECK IF SAME AS CHILD’S) Street City State Zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Social Security Number \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

Father’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dental Insurance**

Policy Holder’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Insurance Company Phone :(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance**

Policy Holder’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Insurance Company Phone :(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person ultimately responsible for account**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to child

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CHECK IF SAME AS ABOVE) Street City State Zip

\_\_\_\_\_\_\_ I hereby authorize assignment of my insurance rights and benefits directly to the provider for

**Initials** services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager prior to treatment. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in the collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Parent or Guardian