Dental Information

Reasons for today's visit? _____

When was child/minor's last dental visit and what treatment was done? _____

_____

Reason for leaving your previous dental office _____

_____

Has child/minor complained of any dental problems? No____ Yes ____If yes, please explain_____
Does child/minor brush daily? No____ Yes____ Floss Daily? No____ Yes ____Take fluoride in any form? No____ Yes____
Has child/minor had any unpleasant dental experiences? No____ Yes ____If yes, please explain_____

_____

Does child/minor have any injuries to the head, mouth or teeth? No____ Yes____
Does child/minor have any mouth habits (thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle)?
No____ Yes ____ If yes, please explain_____

Emergency Contact Information

In the case of an emergency, whom should we contact?

Name_____ Relationship_____ Phone (____)_____

Name_____ Relationship_____ Phone (____)_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor/child ever has a change in health.

Minor/Child Consent
I am the parent, guardian, or personal representative of (minor's name) _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release
I certify that my dependent(s) is covered by insurance with (Insurance Company)_____ and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my child's health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Date_____ Guardian Name (Print)_____Relationship to patient_____

Signature_____

Update (completed at later visit)

Has there been any change in patient's health since last dental appointment? No____ Yes____
If yes, please explain _____
Please list any new medications the patient is taking _____

Date_____ Parent/Guardian Signature_____

Date_____ Doctor Signature_____