WELCOME

to our practice! We strive to make each of your children's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name : _________________Nickname Sex : _______
Birth date ________ Age ________________
Soc. Sec. #
School ___________________ Grade _______________
Child's Home Address
City, State, Zip ___
Phone ______________________

Responsible Party

Name ___________________________________
Relationship ______________________________
Address __________________________________
City, State, Zip ____________________________
Soc. Sec. # _______________________________
DL # ____________________________________

Who is responsible for making appointments?

Name _______________________________________
Home Phone __________________________________
Work Phone Ext _______________________________

How Can We Contact You Directly? ________
____
____

Mother Stepmother Guardian

Name _______________________________________
Home Phone __________________________________
Work Phone Ext. ______________________________
Employer ____________________________________
Occupation ___________________________________
Soc. Sec. # ___________________________________
DL # ____
Marital Status *Single Married Divorced Widowed Separated*

Father Stepfather Guardian

Name __________________________________
Home Phone ____________________________
Work Phone Ext. _________________________
Employer _______________________________
Occupation _____________________________
Soc. Sec. # ______________________________
DL # ___________________________________
Marital Status *Single Married Divorced Widowed Separated*

Primary Insurance

Insured's Name _______________________________
Relationship __________________________________
Birth date _________Soc. Sec. # ________________
Employer _________________Date Employed______
Occupation ___________________________________
Insurance Company ____________________________
Group # ___________Employee # ________________
Ins. Co. address _______________________________
City, State, Zip

Additional Insurance

Insured's Name __________________________
Relationship _____________________________
Birth date ________Soc. Sec. # ____________
Employer ___________Date Employed ______
Occupation ______________________________
Insurance Company _______________________
Group # __________Employee # ___________
Ins. Co. address ___________________________
City, State, Zip ___________________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other___________________

Name of person or office referring you to our practice:____________________________________

Dental & Health History *CONFIDENTIAL* Patient ID #________________________

Your child's overall health as well as any medications, which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely

How often does your child brush?

How often does your child floss?

Is your child's water fluoridated? . . . . Yes No

Does your child take fluoride supplements? . . . . Yes No

Does your child:

Suck thumb/finger . . . . Yes No

Suck/Bite lip . . . . Yes No

Bite/Chew nails? . . . . Yes No

Chew hard objects (pencils, etc.). . . . . Yes No

Grind teeth. . . . . Yes No

Clench jaws . . . . Yes No

Previous dentist ________________________________

Address ____

Date of last dental visit?

Has your child had difficulty with previous dental visits? ………..Yes No

Child's physician _____________________Address ____

Phone # ____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

____ _________________________________

____ _________________________________

____ _________________________________

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? Yes No (if yes, please describe) ______________________________________

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

____

Is your child currently taking medications? Yes No (if yes, please list)

____

Has your child ever had any of the following:

Asthma . . . . Yes No

Cancer . . . . Yes No

Hepatitis . . . . Yes No

HIV/AIDS . . . . Yes No

Hemophilia . . . . Yes No

Abnormal Bleeding . . . . Yes No

Stomach, liver or kidney problems . . . . Yes No

Handicaps/Disabilities . . . . Yes No

Tuberculosis . . . . Yes No

Diabetes . . . . Yes No

Rheumatic Fever . . . . Yes No

Congenital Heart Defect . . . . Yes No

Heart Murmur . . . . Yes No

Convulsions/Epilepsy . . . . Yes No

Please explain any medical problems that your child has: ____

Consent for Services

The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated.

I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I understand that if I have 2 broken appointments, the TCDC will not make any further appointments, unless they are fully prepaid in advance.

I, the undersigned, have insurance with__________________________ and assign directly to TCDC all 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 hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_______________________________ Date: _____________ Relationship to Patient: ____

Signature of guardian ______________________ Date: ________________