



CHILDREN'S DENTISTRY, P.A.
Welcome to our Practice!

PATIENT INFORMATION

Patient's Name _____ Sex _____
Common Name (Nickname) _____ Date of Birth _____
Address _____ School _____
City _____ State _____ Zip _____
Home Phone _____
Father's Name _____ Employer _____
Social Security # _____ Date of Birth _____
Mother's Name _____ Employer _____
Social Security # _____ Date of Birth _____
Name(s) of siblings treated here _____
How did you hear about our office? _____
Address _____ City _____ Zip _____

GUARANTOR INFORMATION

Responsible Party's Name _____
Address _____ Social Security # _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Employer's Name & Address _____
Driver's License # _____ Relationship to Patient _____

INSURANCE INFORMATION

Is the patient covered by Medicaid? YES / NO
Is the patient covered by dental insurance? YES / NO
If so, please complete the following:
Name of Primary Insurance Carrier _____ Policy # _____
Insured's Name _____ Social Security # _____
Employer _____ Date of Birth _____
Name of Secondary Insurance Carrier _____ Policy # _____
Insured's Name _____ Social Security # _____
Employer _____ Date of Birth _____

I certify that the above completed information is true and correct to the best of my knowledge and I will notify Children's Dentistry, P.A. of any changes. I understand and agree that I am responsible for the balance of my account for professional services rendered. I understand that a credit bureau report may be obtained to complete financial information.

Signature of Parent / Guardian / Patient _____ Date _____

**CHILDREN'S DENTISTRY, P.A.
HEALTH HISTORY**

DATE:

PATIENT NUMBER:

Please complete the following:

History

Patient's Name _____ Sex _____

Nickname _____ Date of Birth _____

Height _____ Weight _____

Reason for bringing child to the dentist

Has your child ever been seen by a dentist? Yes ___ No ___

Date last seen _____ Name of dentist _____

Have there been injuries to the face, mouth, or teeth? Yes ___ No ___

Has the patient sucked a thumb or fingers? Yes ___ No ___

If yes, until what age? _____

How many times a day does your child brush? _____

Is your child being treated by a physician at this time? Yes ___ No ___

If yes, why? _____

Is your child allergic to anything? (medicine, food, environment) Yes ___ No ___

If yes, what? _____

Is your child taking any medicine at this time? Yes ___ No ___

If yes, what? _____

Has your child been hospitalized? Yes ___ No ___

If yes, why? _____

Has your child ever received general anesthesia or sedation? Yes ___ No ___

Additional information which you feel would help make your child's association with us more enjoyable:

