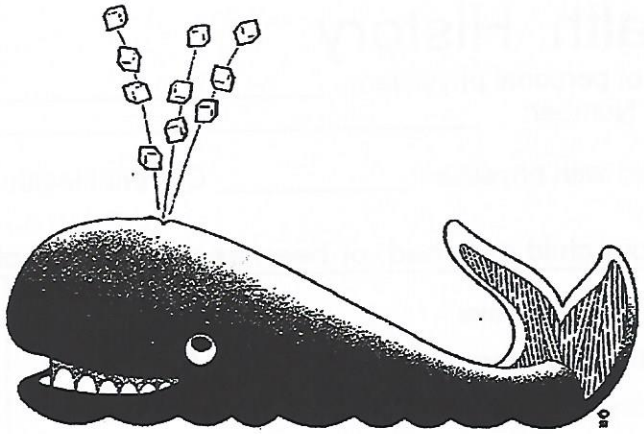
WELCOME to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.



Your Child

Child's Name_____
Nick name_____
Sex____ Birth date_____ Age_____
SS#_____
School_____ Grade _____
Child's Home Address _____
City, State, Zip_____
_____
_____
Phone #_____

❑ Mother

❑ Stepmother ❑ Guardian

Name:_____
Home Phone#:_____
Work Phone #:_____
Employer:_____
Occupation:_____
SS #:_____

Responsible Party

Name:_____
Relationship:_____
Address:_____
_____
_____
Home Phone:_____
Work Phone:_____
SS#:_____

Primary Dental Insurance

Name of Insured: _____
Soc. Sec. # _____
Relationship To Patient: _____
Insurance Company: _____
Group # _____ Name of Employer: _____
Date of Employment:_____
Union or Local #: _____

Parents Martial Status

❑ Single ❑ Divorced
❑ Married ❑ Widowed
❑ Separated

Who is responsible for making appointments?

Name: _____
Home Phone#: _____
Work Phone#: _____
Best time to call:
Time: _____ Day: _____

Health History

Name of personal physician: _____

Phone Number: _____

Last visit with physician:_____ Current Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Has your child ever had, or been treated for any of the following diseases or medical problems?

Heart Attack/Stroke	❑Yes ❑ No	Heart Murmur / Rheumatic Fever	❑Yes ❑ No
Hepatitis/Jaundice	❑Yes ❑ No	High/Low Blood Pressure	❑Yes ❑ No
Epilepsy/Seizures/Fainting	❑Yes ❑ No	Abnormal Bleeding	❑Yes ❑ No
Cancer/Chemotherapy	❑Yes ❑ No	Kidney Problems	❑Yes ❑ No
Psychiatric Problems	❑Yes ❑ No	Diabetes	❑Yes ❑ No
Tuberculosis	❑Yes ❑ No	Drug/Alcohol Abuse	❑Yes ❑ No
AIDS/HIV	❑Yes ❑ No	Anemia	❑Yes ❑ No

Please explain any medical problems that your child has:_____

_____

_____

_____

How often does your child brush?_____

How often does your child floss? _____

Does your child:

Suck thumb/finger.....	❑Yes ❑ No	Bite/Chew nails.....	❑Yes ❑ No
Chew hard objects (pencils, etc.).....	❑Yes ❑ No	Grind Teeth.....	❑Yes ❑ No
Clench jaws.....	❑Yes ❑ No	Take a fluoride supplement.....	❑Yes ❑ No

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provided proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18%) APR) may be added to my account.
5. I also agree that should it be needed, I will be responsible for all collection costs; which may include, but is not limited to: collection costs, attorney's fees, court fees.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option which you prefer. Payment in full at each appointment: ❑ Cash ❑Personal Check Credit Card: ❑Visa ❑MC ❑Discover