Child's History

Name of Child:______________________________ Date:___________________________

Date of Birth:_______________________________ Gender: M F Other

Name of Parent or Guardian:________________________ Phone Number:__________________

Emergency Contact:__________________________ Phone Number:___________________

Relationship: ________________________________

Reason for Today's Visit:____

Is this your child's first dental visit? ____

If not, previous dentist name:_____________________________ Phone#: ________________

Address:____

Was the previous visit a good one? ____

Has your child received local anesthetic before?.. Yes No

Does your child have a bottle at nap or bedtime? .... Yes No

Does your child have a thumb-sucking or pacifier Habit?.............................. Yes No

Who Brushes your child's teeth? ____

How often your child teeth does brushed? ____

How often are you child's teeth flossed? ____

What is your child favorite snack between meals? ______________________________________

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

Is your child taking fluoride Supplements?.. Yes No

Has your child had a serious problem at a previous dental Visit?................... Yes No

If yes, Please explain: ____

Do you believe your child can tolerate routine dental care?.......................... Yes No

If no, please explain: ____

Has your child ever seen an orthodontist?... Yes No

Child's Medical History

Name of Child's Physician: ______________________ Phone Number:_________________

Date of last visit: ___________________

Does your child have any allergies to medications? .... Yes No

If yes, please list:____

Are there other allergies: Latex, food, pollen, other?.................................. Yes No

If yes, please explain:____

Does your child have reaction to local anesthetics?.................................... Yes No

Has your child had a serious illness or operation?....................................... Yes No

Has your child ever been hospitalized?.. Yes No

If yes, when and why? ____

Does your child have, or has your child ever had any of the following? Check all that apply:

ADD/ ADHD	Diabetes	Hemophilia
AIDS/ HIV Positive	Digestive Problems	Kidney Problems
Anemia	Epilepsy or Seizures	Liver Disease
Asthma	Fainting	Neurological Disorder
Autism	GERD/Reflux	Psychiatric Care
Bleeding Disorder	Hearing Impairment	Tobacco Habit
Breathing/ Sleep Disorder	Heart Murmur	Tuberculosis
Cancer	Heart Problems	Scarlet/Rheumatic Fever
Developmental Delay	Describe:______________________________________	

Any other medical conditions?.. Yes No

If yes, please explain:____

Does your child require an antibiotic prior to dental treatment?......................... Yes No

List all Medications you child is currently taking? ______________________________________

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Parent/guardian Signature:________________________ Relationship:____________________

OFFICE FINANCIAL POLICY

Payment is due at the time of treatment. We will either bill your dental insurance plan, or if you do not have dental insurance; we will accept cash, check, and/or major credit cards.

PAYMENT OPTIONS:

---PRIVATE PAYMENT:

1) **Cash, personal check, or money order**
2) **Major credit card – i.e. – Visa, Mastercard, Discover, and American Express**

Please indicate below the form of payment you choose to settle your account:
Check one:

- o Cash, check or money order
- o Major credit card

____ ____________

Signature of Patient/Responsible party **Date**

---INSURANCE BILLING:

For our office to accept assignment of benefits from your dental plan, we ask that you read this document and accept the guidelines and policies set forth.

1) Your dental plan is a contract between you and your insurance carrier. We are not a party to that contract. It is your responsibility to understand your benefits as defined by your plan.
2) You are responsible for payment of all charges incurred in this office. Some, if not all of your treatment may not be covered by your dental plan. You are responsible for any finance charges on any outstanding balances. Future services, both dental and clerical may be refused until the balance is cleared.
3) If your dental plan has not paid the assigned balance in full by 90 days from the date the charges were incurred, we require you pay the balance.
4) We will not bill our dental plan unless you provide us with accurate information required by your plan in order to submit for a dental claim.
5) If necessary, we will submit a claim for payment twice to your dental plan. However, if there is no resolution, it is the responsibility of the insured to contact their dental plan and seek payment. We will only provide further assistance once the balance is paid in full.

I have read the above and I understand and agree to abide by this policy. I authorize my insurance carrier to assign dental benefits to this office. I also authorize the release of any information necessary to process my dental claim.

____ ____________

Signature of Patient/Responsible party **Date**