WELCOME

Dentistry for Children

Prevention Is Everything

About Your Child

Today's Date:_____/_____/_____ File#:_____

Child's Name:_____
LAST FIRST MI

Child's Nickname:_____ ❑ Boy ❑ Girl

Child's Birthdate:_____/_____/_____ Age:_____

School:_____ Grade:_____

Child's Home Phone #: (_____) _____

Child's SS#:_____

Child's Address:_____

_____
CITY STATE ZIP

Referred By: _____
(if doctor please give address & phone number)

_____

Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters?_____ Ages?: ___ ___ ___

_____ _____
MOTHER'S NAME ❑ STEP MOTHER ❑ GUARDIAN EMAIL ADDRESS

_____
(❑ **CHECK IF SAME AS CHILD'S**) HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVER'S LIC. #

_____ _____
FATHER'S NAME ❑ STEP FATHER ❑ GUARDIAN EMAIL ADDRESS

_____
(❑ **CHECK IF SAME AS CHILD'S**) HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVER'S LIC. #

Employer:_____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Insurance Info or Dental Membership

❑ Insurance Patient

Primary Dental Insurance

Co. Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID #:_____

Group # (Plan, Local or Policy #)_____

Insured's Name:_____

Relation:_____ Date of Birth:____/____/____

Insured's Employer:_____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID #:_____

Group # (Plan, Local or Policy #)_____

Insured's Name:_____

Relation:_____ Date of Birth:____/____/____

Insured's Employer:_____

❑ Membership Patient

I acknowledge to have fully read and signed the Medical Retainer Agreement attached to this New Patient Form presented to me by Westside Family Dental Group.

Account Info

Person ultimately responsible for account

Name: _____
LAST FIRST MI

Relation to child: _____

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVER'S LIC. #

Work Phone #: (_____)_____ Ext:_____

Cell Phone #: (_____)_____

Payment Method: ❑ Cash ❑ Check

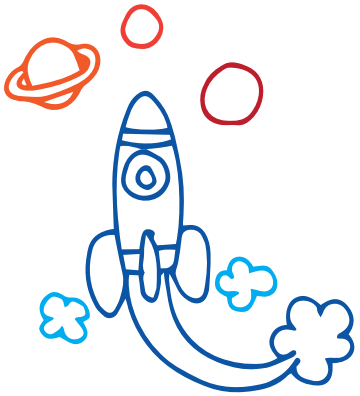
_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials

I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

Please continue on back



Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation
Is Child in pain? ❑ No ❑ Yes How Long?_____
Please indicate any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums.	❑ Teeth grinding	❑ Locking jaw
❑ Sensitive tooth, teeth or gums.	❑ Ringing in ears	❑ Bad breath
❑ Blisters/sores in or around the mouth.	❑ Broken/Chipped tooth	❑ Loose tooth

❑ Other:_____
Do Child require pre-medication? ❑ Yes ❑ No ❑ Don't know
Previous Dentist:_____ (_____)_____
NAME PHONE #
Last Dental Exam:____/____/____ Last Dental X-rays:____/____/____
Times a day child brushes?_____ Times a week child flosses?_____
Is the child's water fluoridated? ❑ Yes ❑ No
How would you rate the child's smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Child's Medical History

Is Child taking any of the following medication? ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Ritalin** ❑ **Stimulants** ❑ **Blood thinners** ❑ **Tranquilizers** ❑ **Insulin**
❑ **Other(s),** please list:_____
Child's Physician:_____ (_____)_____
DOCTOR'S NAME OR CLINIC'S NAME PHONE #
_____ Last Medical Exam:____/____/____
ADDRESS CITY STATE ZIP

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Reumatic Fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart Defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancers/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting / Seizures / Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** CerebralPalsy

Please list any other surgeries or medical conditions Child has or ever had:_____
_____
Is Child allergic to: ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics (Novocaine) ❑ Foods:_____ ❑ Others:_____
Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑ Yes ❑ No
Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How Long?_____ Child's blood type:_____
Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collecting agency fees, interest in charges and any other expenses incurred in collecting your account.
I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
I understand the above information and guarantee this form was completely correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in the information I have provided.

_____ I acknowledge that I have received a copy of the Summary of Privacy Notice.
Initials

Signature _____ Date ____/____/____
❑ Parent or Guardian ❑ Other

UPDATE
(OFFICE USE)

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments