WELCOME!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Today's Date _____

Tell Us About Your Child

Child's Name: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female

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

School: _____ Grade: _____

Child's Home #: _____ S.S.#: _____

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

Who is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____
(circle one)

Last Visit Date: _____

Parent's Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Mother's Information ❑ Stepmother ❑ Guardian

Name: _____

Work #: _____ Ext: _____ Home #: _____

Employer: _____

S.S. #: _____ DL#: _____

Father's Information ❑ Stepfather ❑ Guardian

Name: _____

Work #: _____ Ext: _____ Home #: _____

Employer: _____

S.S. #: _____ DL#: _____

Why did you bring the child to the dentist today?

_____

_____

Has the child ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Is the child's water flouridated? ❑ Yes ❑ No

Is the child taking flouridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush their teeth daily? ❑ Yes ❑ No

Floss their teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

Please list all drugs that the child is allergic to:

_____

_____

Has the child ever had any of the following medical problems?

Y N	Abnormal Bleeding	Y N	Heart Murmur
Y N	Allergies to any Drugs	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV+ or AIDS
Y N	Congenital Heart Defect	Y N	Kidney/Liver Problems
Y N	Convulsions/Epilepsy	Y N	Rheumatic Fever
Y N	Diabetes	Y N	Tuberculosis
Y N	Handicaps/Disabilities	Y N	Any Operations
Y N	Hearing Impairment	Y N	Any Stays in the Hospital

PLEASE DISCUSS ANY SERIOUS MEDICAL CONDITION(S) THAT THE CHILD HAS HAD: _____

_____

_____

Does the child have any of the following habits?

Y N	Thumb/Finger Sucking	Y N	Nail Biting
Y N	Nursing Bottle Habits	Y N	Lip Sucking/Biting

Dr. John L. Shannon, D.D.S. • 2704 E. Nettleton Avenue • Jonesboro, AR 72401 • (501) 932-9886

CONTINUED ON BACK OF FORM

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ & S.S.#: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ & S.S.#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: _____ Work #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Work #: _____ Ext: _____ Home #: _____

Employer: _____

S.S.#: _____ D.L. #: _____

I OR WE AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE DUE TO THE HEALTH CARE PROVIDER FOR SERVICES RENDERED.

IF YOU HAVE DENTAL INSURANCE, WE WANT YOU TO RECEIVE THE FULL BENEFIT OF IT. OUR OFFICE STAFF CAN ASSIST YOU IN COMPLETING YOUR INSURANCE FORMS AND VERIFYING THE COVERAGE THAT YOUR PARTICULAR PROGRAM PROVIDES. WE ACCEPT ASSIGNMENT OF YOUR INSURANCE PAYMENT; ANOTHER SERVICE TO YOU. THIS MEANS THAT YOU ARE RESPONSIBLE FOR YOUR DEDUCTIBLE AND THE PORTION THE INSURANCE DOES NOT COVER WHEN YOU SEE THE DOCTOR. REMEMBER, HOWEVER, THAT YOU ARE RESPONSIBLE FOR THE ACCOUNT IF THE INSURANCE COMPANY, FOR ANY REASON, DOES NOT HONOR THEIR COMMITMENT TO YOU AND TO US.

_____ _____
Responsible Party Signature Date

_____ _____
Responsible Party Signature Date

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ _____
Authorized Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____
Signature Date

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY •

Medical History Update

1. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
2. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
3. Date: _____ Comments: _____ Signature _____ Dr. Initials _____
4. Date: _____ Comments: _____ Signature _____ Dr. Initials _____

Dr. John L. Shannon, D.D.S. • 2704 E. Nettleton Avenue • Jonesboro, AR 72401 • (501) 932-9886