Child's Name	Age	Birth date	Male Female	(Please Circle correct answers)

Child's Home Address	City	State	Zip	Who resides at this address? Father / Mother / Both / Guardian _____

Name	Home Phone	Cell Phone	Business Phone	Email address
Father's _____				
Mother's _____				

Which phone is the best daytime contact? _____
How may we contact you confirm to appointments? Phone Text Email
How did you hear about this office? Yellow Pages / Insurance Plan / Sign /
Referred by:
Friend / Relative _____ / Parent of Dr Foreman's Patient _____ / Other Doctor_____

Person Responsible to Pay for Services: Father / Mother / Both / Guardian / Non-custodial
Do you have dental benefits through your employer? Yes / No
Do you have dental benefits through the state? Yes / No
Preference of payments due on day of service: Cash / Check / Major Credit Card / Care Credit

Insurance Plan(s) covering child: Father / Mother / Both / Other: _____

INSURANCES	PRIMARY	SECONDARY
Subscriber's Name		
Social Security Number or Insurance ID Number		
Subscriber's Date or Birth		
Subscriber's Employer		
Insurance Company		
Insurance Company Phone Number		

TERMS AND CONDITIONS

This Office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance, all emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

Please circle correct answer

Why have you brought your child to visit us today? Routine examination and cleaning / Pain

Other Concerns: _____

Is this your child's first visit to a dentist? Yes / No Who brushes your child's teeth? Parent / Child / Both

How often are your child's teeth brushed? 2 X day / 1 X day / ___ X week

How often are your child's teeth flossed? 2 X day / 1 X day / ___ X week

Does your child suck on a pacifier or thumb? Yes / No

Has your child ever had a serious problem at a previous dental visit? *(if so, please explain)*

_____

_____

Do you believe that your child will have difficulties tolerating routine dental care? *(if so, please explain)*

_____

_____

CHILD'S MEDICAL HISTORY

Name of Child's physician _____ Phone _____

Is you child allergic to: Injected local anesthetics Yes / No; Penicillin Yes / No

Allergies to any other Medications _____

Has your child ever been diagnosed with or treated for:

Yes	No	Heart disease or heart mummer	Yes	No	Hearing Loss	Any Other Medical Conditions:
Yes	No	Asthma	Yes	No	Seizures	
Yes	No	Diabetes	Yes	No	Emotional Problems	_____
Yes	No	Arthritis	Yes	No	DSD/ Autism spectrum	
Yes	No	Prolonged Bleeding	Yes	No	Physical Disability	_____
Yes	No	Hepatitis	Yes	No	Mental Disability	
Yes	No	Lung disease/ TB				_____

Does your child usually take an antibiotic prior to dental treatment? Yes / No

List all medications your child is currently taking, their doses, and conditions for which they are prescribed.

_____

_____

In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name of nearest relative not living with child _____

Please sign below confirming that the parent or legal guardian completed this form

Parent/Guardian's Signature: X_____ Doctor's Signature: _____

Limited Power of Attorney

(fill out only if an adult, other than a legal guardian, will accompany child to dental appointments)

I, the undersigned, hereby authorize _____, to bring in _____ to receive dental treatment.

Signature of Parent or Guardian X _____ Date _____

I give my permission for this office to administer any necessary treatment in the event of a medical emergency to:

Patient's Name _____ Signature of Parent/Guardian _____ Date _____