Child's Name	Age	Birth date	Male Female

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/ Guardian _____	_____	_____	_____	_____
Mother/Guardian _____	_____	_____	_____	_____

How may we confirm appointments? Phone / Text / Email

How did you hear about us? Facebook / Online Search / Insurance Plan / Sign / Friend/Relative / Another Doctor / Other

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

INSURANCES	PRIMARY	SECONDARY
Subscriber's Name		
Social Sec # / Ins. ID #		
Subscriber's Date or Birth		
Subscriber's Employer		
Insurance Company		
Insurance Co. Phone #		

CHILD'S MEDICAL HISTORY

Does your child have allergies? Yes No To what? _____

Has your child ever been diagnosed with or treated for:

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

Fluoride use:

Yes No Does your family use fluoride toothpaste?
Yes No Would you like professional fluoride treatments?

Anything else you would like us to know about your child?
_____

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 (NOT Guardians):

Name _____ Relationship _____Phone_____

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

Signature of Parent/Guardian _____ Date_____

Limited Power of Attorney

(fill out if an adult, OTHER than a legal guardian(s), will EVER accompany child to dental appointments on your behalf)

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

Signature of Parent or Guardian X _____ Date _____

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 _____