

# Spring Children's

## DENTISTRY

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with your child.

### Patient Information

Child's Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last Name First Name Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Sex M / F Age \_\_\_\_\_ Birthday \_\_\_\_\_ School \_\_\_\_\_

Grade \_\_\_\_\_ Hobbies/Sports \_\_\_\_\_

Child's pets \_\_\_\_\_

Names of siblings \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency? \_\_\_\_\_

### Responsible Party

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to child \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Email \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

Please complete both sides.

# Dental History

What would you like us to do for you today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss \_\_\_\_\_

Does your child experience pain or discomfort in the jaw joint? Yes / No

Has your child ever experienced mouth or chin injury? Yes / No

Does your child have speech problems? Yes / No

Has your child experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes / No

Child's habits affecting the mouth or teeth: Thumb sucking Nail biting Other \_\_\_\_\_

Other information about your child's dental health or previous treatment \_\_\_\_\_

# Medical History

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit Date \_\_\_\_\_

Has your child had any serious illness or operations? Y / N

If yes, describe \_\_\_\_\_

Is your child currently under physician care? Y / N

If yes, describe \_\_\_\_\_

List medications your child is taking \_\_\_\_\_

List drug allergies if any \_\_\_\_\_

Has your child had blood transfusion? Y / N If yes, give approximate dates \_\_\_\_\_

## Circle Yes or No - whether your child has had any of the following:

Y/N AIDS/HIV Positive    Y/N Cough up blood    Y/N Hemophilia/ Abnormal bleeding    Y/N Shortness of breath

Y/N Anemia    Y/N Diabetes    Y/N Immunizations current    Y/N Sinus problems

Y/N Asthma    Y/N ADD/ADHD    Y/N Kidney disease or malfunction    Y/N Skin rash

Y/N Atopic(allergy prone)    Y/N Fainting    Y/N Liver disease    Y/N Spina Bifida

Y/N Autistic    Y/N Food Allergies(Nuts)    Y/N Material allergies (**Latex**, wool, metal,chemicals)    Y/N Thyroid disease or malfunction

Y/N Cancer    Y/N Hearing Impairment    Y/N Penicillin allergy    Y/N Tonsillitis

Y/N Chicken Pox    Y/N Heart Problems  
Heart murmur    Y/N Respiratory disease    Y/N Tuberculosis

Y/N Convulsions/Epilepsy/ Describe \_\_\_\_\_    Y/N Rheumatic/Scarlet fever    Y/N Other \_\_\_\_\_  
Seizures

## Authorization

I have reviewed the information on this questionnaire, and it is to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all the insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Payment is due in full at the time of treatment, unless prior arrangements have been approved**