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/ Seizures	Describe _____	Y/N Rheumatic/Scarlet fever	Y/N Other_____

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