

WELCOME TO OUR PRACTICE!



PATIENT INFORMATION - CHILDREN FORM

Today's Date _____

Child's Name: _____ Nickname: _____

Last First Middle

Date of Birth: _____ Age: _____ Sex: F M School: _____

Child's Home Phone #: _____ Email: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Name and Age of Brothers/Sisters: _____

Interests or Hobbies: _____

Whom may we thank for referring you? _____

Person Responsible for Account: _____ Relation: _____

Work # _____ ext. _____ Home #: _____ SSN: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

PARENT'S INFORMATION

FATHER Step-father Guardian

MOTHER Step-mother Guardian

Name _____ DOB _____ Name _____ DOB _____

Wk # _____ ext _____ Hm# _____ Wk # _____ ext _____ Hm# _____

Employer _____ Employer _____

Occupation _____ Occupation _____

SS# _____ Email _____ SS# _____ Email _____

INSURANCE INFORMATION

DENTAL INSURANCE

Insurance Co.: _____ Group (Policy) #: _____

Ins. Co. Address: _____ Insurance Co. Phone #: _____

Policy Owners Name: _____ Relationship to Patient: _____

Policy Owner's DOB: _____ SSN: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Tong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Relationship _____ Date _____

Responsible Party Signature

Child's Name _____ DOB _____

DENTAL HISTORY

Why did you make this appointment? _____

Has the child ever had an unpleasant dental experience? No Yes _____

Have the child's teeth ever been injured? No Yes _____

Were there any complications with the birth or pregnancy? No Yes _____

Has the child ever had any pain/tenderness or popping/noise in his/her jaw ? No Yes _____

Is the child nervous about this appointment? No Yes Does/Did the child have any of the following habits:

Is the child's drinking water fluoridated? No Yes Bottle to bed at night Use a pacifier

Is the child taking fluoridated supplements? No Yes Thumb/finger sucking Lip sucking/biting

Does the child brush his/her teeth daily? No Yes Mouth breathing Grinds teeth

Do you help the child brush? No Yes Other _____

Does the child floss his/her teeth daily? No Yes Date of last dental examination: _____

Was the child breast fed? No Yes Names of previous dentist: _____

MEDICAL HISTORY

Child's Physician: _____ Phone # _____

Is the child currently under the care of a physician? No Yes Date of last physical exam: _____

Does the child have any history of the following diseases or conditions?

- | No | Yes | No | Yes | No | Yes |
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Please discuss any serious medial problems that the child has had: _____

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: _____

Please describe any hospital stays of the child: _____

AUTHORIZATION

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services the child may need.

Signature of Parent/Guardian Relationship Date