



## Welcome!

Thank you for selecting our dental healthcare team for your Child!

We will strive to provide your child with the best possible dental care.

To help meet all your dental healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us – we will be happy to help.

### Patient Information (Confidential)

Patient # \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

### Parent or Responsible Guardian (Must Sign Form)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Birth date \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

What is the best way to reach you?  Phone  Cell Phone  Mail  Other \_\_\_\_\_

May we leave a message for you on your answering machine/ voice mail?  Yes  No

How did you here about our office? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

\*\*\*\*\*Is any member of the child's immediate family a patient in our office?  Yes  No \*\*\*\*\*

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card -Visa, MasterCard, Discover  I wish to discuss the office's payment policy

### Insurance Information (Please Present Card to be Copied)

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Have Benefits Been Used this Year?  Yes  No

Do you have additional insurance?  Yes  No If Yes, Complete the following:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Have Benefits Been Used this Year?  Yes  No

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No		Yes	No
Is your child under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Has this child ever been diagnosed with any of the following conditions?</b>			Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Had any surgery or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Received General Anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Taking any medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what? _____			Cancer If yes: Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
_____			Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<b>Organs and Systems:</b>		
_____			Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever been treated		
Is your child allergic to anything food/drug?			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	for any of the following?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Diphtheria/ Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Blood- Circulatory	<input type="checkbox"/>	<input type="checkbox"/>
_____			Emotional Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Bones	<input type="checkbox"/>	<input type="checkbox"/>
Does your child participate in sports?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>
If so what sports? _____			Excessive Bleeding/ Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Protection worn?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal (Stomach)	<input type="checkbox"/>	<input type="checkbox"/>
Use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney - Bladder	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, what Form _____			Infective Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>
How Long _____			Hepatitis – Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>
Use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS infection	<input type="checkbox"/>	<input type="checkbox"/>	Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Measles/Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System	<input type="checkbox"/>	<input type="checkbox"/>
Older Girls Only:			Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant/think you may be?	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoids	<input type="checkbox"/>	<input type="checkbox"/>
						Other or Explain any yes answers: _____		

## Patient Dental History

Has your child ever been seen by a dentist before Yes  No

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Does your child suck his/her thumb or fingers? Yes  No

Are your child's teeth brushed once a day? Yes  No

What type of toothpaste does your child use? \_\_\_\_\_

Has your child Ever Received Fluoride Before? Yes  No  If yes, what form \_\_\_\_\_

At what age did your child Stop bottle/breast feeding? \_\_\_\_\_ Do you have well or city water? \_\_\_\_\_

## Consent for Examination and Treatment

I authorize Dr. Honeycutt or an Associate Doctor and/or his staff to examine and treat my child. Examination may include Dental Films and Photographs. Treatment may include but is not limited to cleaning of teeth, application of fluoride, application of sealants, filling of diseased, decayed, or injured teeth, removal (extraction) of teeth, replacement of missing teeth with dental prosthesis, treatment of diseased or injured oral tissues (hard and/or soft), Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities, etc. Please understand that some physical restraint and voice control may be necessary to avoid injury to your child and/or the staff and to allow communication to take place. We want your child to have a good dental experience and appreciate your assistance in achieving this goal, in many cases this is best achieved by the parent remaining in the waiting area so the Dr. can have the child's undivided attention. I understand that this consent will remain in effect until such time that I choose to terminate it in writing.

## Authorization and Release

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I agree to notify the office of any changes to my child's health or patient information. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I default on this agreement I agree to be responsible for all finance charges and/or collections and attorney expenses incurred. I am aware of the privacy practices and a Notice of Privacy Practices is available to me.*

X

Signature of Parent or Legal Guardian \_\_\_\_\_

Updates/Comments: \_\_\_\_\_