



Welcome to our office! In order to provide you with the best possible service, please fill out this form as completely as possible with black or blue ink. Please let us know if you have any questions or concerns. Thank you!

1 ABOUT YOUR CHILD

Date: _____

Child's name: _____
FIRST MI LAST

Preferred name: _____ Gender: MALE FEMALE

Birthdate: _____ Age: _____ SSN: _____

School: _____ Grade: _____

Home address: _____

Home phone: (_____) _____ - _____

How did you hear about us? _____

IF YOU WERE REFERRED BY A DOCTOR, PLEASE LIST THEIR CONTACT INFO

2 FAMILY INFO

Who is accompanying this child today?
Full name: _____ Relation: _____
(IF NOT CHILD'S PARENT)

Do you have legal custody of this child? YES NO

Brothers/Sisters? YES NO If so, please list ages: _____

Mother's name: _____ Email address: _____
 STEPMOTHER GUARDIAN

Mailing address: _____
 SAME AS CHILD'S? _____

Primary contact number: (_____) _____ - _____ Ext: _____

Alternate contact number: (_____) _____ - _____ Ext: _____

Mother's SSN: _____ Birthdate: _____

Employer: _____ How long? _____

Employer's address: _____

Father's name: _____ Email address: _____
 STEPFATHER GUARDIAN

Mailing address: _____
 SAME AS CHILD'S? _____

Primary contact number: (_____) _____ - _____ Ext: _____

Alternate contact number: (_____) _____ - _____ Ext: _____

Father's SSN: _____ Birthdate: _____

Employer: _____ How long? _____

Employer's address: _____

3 ACCOUNT INFO

PRIMARY ADULT RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
(TO CHILD)

SSN: _____ Driver's license number: _____

Billing address: _____

4 INSURANCE

PRIMARY DENTAL	SECONDARY DENTAL (IF APPLICABLE)
Company name: _____	Company name: _____
Address: _____ _____	Address: _____ _____
Phone: (_____) _____ - _____	Phone: (_____) _____ - _____
Subscriber's name: _____	Subscriber's name: _____
Subscriber's ID: _____ Group number: _____ <small>PLAN, LOCAL, OR POLICY NUMBER</small>	Subscriber's ID: _____ Group number: _____ <small>PLAN, LOCAL, OR POLICY NUMBER</small>
Birthdate: _____ Relation: _____ <small>(IF APPLICABLE)</small>	Birthdate: _____ Relation: _____ <small>(IF APPLICABLE)</small>
Subscriber's employer: _____	Subscriber's employer: _____

I hereby authorize the assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

INITIALS

5 DENTAL HISTORY

Reason for your visit: EXAM EMERGENCY CONSULTATION

Is the child in pain? YES NO If so, please describe. _____

Do you have any of the following problems? Select all that apply.

- CHIPPED TOOTH LOST/DAMAGED FILLING IRRITATED/SWOLLEN GUMS
 LOCKING JAW STAINED TEETH SENSITIVITY IN TEETH/GUMS
 JAW DISCOMFORT TEETH GRINDING SORES IN OR AROUND MOUTH
 BAD BREATH OTHER: _____

Does the child require pre-medication? YES NO NOT SURE

Previous dentist: _____ Phone: () _____ - _____

Last dental exam: _____ Last dental X-rays: _____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? YES NO

6 MEDICAL HISTORY

Are you allergic to any of the following: ASPIRIN DENTAL ANESTHETICS LATEX PENICILLIN/AMOXICILLIN TETRACYCLINE FOODS: _____ OTHER: _____

Is the child taking any of the following medications: BLOOD THINNERS INSULIN MUSCLE RELAXERS PAIN KILLERS (including aspirin) RITALIN STIMULANTS TRANQUILIZERS

OTHER: _____

Does the child have any of the following: HEAVY SNORING LIP BITING/SUCKING MOUTH BREATHING THUMB/FINGER SUCKING TONGUE THRUSTING

Do you have or have you had any of the following diseases, medical conditions, or procedures? Select all that apply, or select NO .

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> DIABETES/HYPOGLYCEMIA | <input type="checkbox"/> LEUKEMIA |
| <input type="checkbox"/> ARTIFICIAL BONES/JOINTS | <input type="checkbox"/> FAINTING/SEIZURES/EPILEPSY | <input type="checkbox"/> LIVER PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL VALVES | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> ORGAN PROBLEMS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PSYCHIATRIC PROBLEMS |
| <input type="checkbox"/> BIRTH DEFECTS | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> BLOOD TRANSFUSION(S) | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CANCER/TUMORS | <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> SURGERIES/OPERATIONS |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HYPER ACTIVE (ADD) | <input type="checkbox"/> TONSILLITIS |
| <input type="checkbox"/> CLEFT LIP/PALATE | <input type="checkbox"/> JAW PROBLEMS (TMJ/TMD) | <input type="checkbox"/> TUBERCULOSIS (TB) |

Please list any other surgeries or medical conditions the child has or have ever had: _____

Please rate the child's general health from 1 to 10: _____ Do you wear contact lenses? YES NO
WHERE 10 IS EXCELLENT

Has the child ever taken the drug Ritalin? NO YES How long? _____ Child's blood type: _____

I understand that full payment is required for all services rendered at the time of my visit, unless other arrangements have been made.

I understand that if my balance is not paid within 90 days from the date of service and no other arrangements have been made, I will be charged a statement fee of 1% of my unpaid balance per month and any other expenses necessary to collect the money I owe.

I authorize the staff of Phillippi and Kwon Family Dentistry to perform any necessary services needed during my diagnosis and treatment.

I authorize the staff of Phillippi and Kwon Family Dentistry to release any information required to process insurance claims.

I certify that I have completed this form to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____

Date: _____

PARENT/GUARDIAN OTHER: _____

Please let us know if you have any questions or concerns. Thank you!

