BRUSH SMILES DENTIST HEALTHY
DENTIST HEALTHY GUMS HYGIENIST
TOOTHPASTE CHECKUP NO CAVITIES HEALTHY GUMS HYGIENIST TEETH DENTIST
TEETH HYGIENIST TEETH NO CAVITIES CHECKUP GUMS

WELCOME

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 ______________ ______________ ______ Soc. Sec. # ______________
Last Name *First Name* *Initial*

Address ______________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ❑ M ❑ F Age ______________ Birthdate ______ School ______________

Grade ______________ Hobbies/Sports ______________

Whom may we thank for referring you? ______________

Notify in case of emergency ______________ Home Phone ______________

Business Phone ______________ Cell Phone ______________ Email ______________

PRIMARY INSURANCE

Person Responsible for Account ______________ ______________ ______
Last Name *First Name* *Initial*

Relation to Child ______________ Birthdate ______________ Soc. Sec. # ______________

Address *(if different from child)* ______________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________ Email ______________

Person Responsible Employed by ______________ Occupation ______________

Business Address ______________ Business Phone ______________

Business Email ______________ Insurance Email ______________

Insurance Company ______________ Phone ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name ______________ Relation to Child ______________ Birthdate ______________

Address *(if different from child)* ______________ Soc. Sec. # ______________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________ Email ______________

Subscriber Employed by ______________ Business Phone ______________

Business Email ______________ Insurance Email ______________

Insurance Company ______________ Phone ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________

Please complete both sides.

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DENTAL HISTORY

What would you like us to do for your child today? ____________________

Former Dentist ____________________ Address ____________________

Dentist's Email ____________________ 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? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems?

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

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 ____________________

Physician's Email ____________________

Date of last visit ____________________ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ____________________

Is your child currently under physician care? ❑ Y ❑ N If yes, describe ____________________

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ____________________

Has your child ever taken Fen-Phen/Redux? ❑ Y ❑ N

Check (✓) 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 Epilepsy	❑ 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 Blood disease	❑ Y ❑ N Food allergies	❑ Y ❑ N Material allergies (latex, wool, metal, chemicals)	❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Cancer	❑ Y ❑ N Headaches	❑ Y ❑ N Respiratory disease	❑ Y ❑ N Tonsillitis
❑ Y ❑ N Chicken Pox	❑ Y ❑ N Hearing Impairment	❑ Y ❑ N Rheumatic/Scarlet fever	❑ Y ❑ N Tuberculosis
❑ Y ❑ N Convulsions/Epilepsy	❑ Y ❑ N Heart problems		❑ Y ❑ N Other
❑ Y ❑ N Cough, persistent	Describe ____________________		Describe ____________________

List medications your child is taking, if any: ____________________

List drug allergies, if any: ____________________

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate 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 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 time of treatment, unless prior arrangements have been approved.

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