Thank you for taking the time to provide us with the following information!
CHILDREN'S DENTAL CENTER AND BIG PEOPLE, TOO!

PLEASE PRINT **Date:** ____________________

I. PATIENT INFORMATION

Child's Name ________________________________ M ______ F ______
First Middle Last

Nickname ____________ S.S.# ______-______-______ Date of Birth ____________ Age ________

Address ____
Street City State Zip

Home Phone ______________ School ________________ Grade __________

Whom may we thank for referring you to our office? ________________________
Names and ages of other children in family ________________________

____

Nearest relative NOT living with child: Name ________________________
Home Address ________________________ Home Phone ________________
Relationship to Child ________________________ Work Phone ________________

II. PARENT/GUARDIAN INFORMATION

A. Father's Name ________________________ S.S.# ______-______-______ D.O.B. ________
First Middle Last
Home Address if Different ________________________________
Street City State Zip
Home Phone ______________ Work Phone ______________ Cell Phone ______________
Employed by ________________________________
Date Employed ______________ Occupation ________________________
Dental Insurance Company ________________________ Group No. ______________
Address ________________________________ Phone ______________

B. Mother's Name ________________________ S.S.# ______-______-______ D.O.B. ________
First Middle Last
Home Address if Different ________________________________
Street City State Zip
Home Phone ______________ Work Phone ______________ Cell Phone ______________
Employed by ________________________________
Date Employed ______________ Occupation ________________________
Dental Insurance Company ________________________ Group No. ______________
Address ________________________________ Phone ______________

C. Legal Guardian's Name ________________________ M ____ F ____ Relationship ________
First Middle Last
Home Address ________________________________
Street City State Zip
Occupation ________________________ S.S.# ______-______-______ D.O.B. ________
Work Phone ______________ Home Phone ______________ Cell Phone ______________

D. Person or agency responsible for child's account, if other than parent: Name ______________
Address ________________________________ S.S.# ______-______-______
Street City State Zip
Phone ________________________ Relationship to Child ________________

-OVER-

E. I authorize my insurance company 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, whether manual or electronic.

Signature of Insured ____________________ Relation to patient ____________________ Date __________

Signature of Insured ____________________ Relation to patient ____________________ Date __________

III. DENTAL HISTORY

Former Dentist Name ______________________________ Phone ______________

Date of last visit to dentist ______________ For what service? ______________________

Has child complained about dental problems? .... ☐ YES

Does child brush teeth daily? .... ☐ YES

Does child use floss every day? .... ☐ YES

Is fluoride taken in any form? .... ☐ YES

Any injuries to mouth, teeth, head? .... ☐ YES

Any unhappy dental experiences? .... ☐ YES

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ...... ☐ YES

IV. HEALTH HISTORY

Physician's Name ____________________ Address ______________________________ Tel __________

A. Is your child taking any medication or drugs, including birth control? ☐ YES
   Please List ______________________________

B. Is your child sensitive or allergic to any medication, drugs or latex? ☐ YES
   Please Explain ______________________________

C. Is your child under medical care at present? ☐ YES
   Please Explain ______________________________

D. Has your child any history of being under general anesthesia or oxygen? ☐ YES
   Please Explain ______________________________

E. Is your child pregnant? ☐ YES

F. Does`your child have any history of the following? **(CHECK ONLY THOSE BOXES THAT APPLY)**

A.I.D.S .... ☐ Yes
Allergies or Hives .... ☐ Yes
Anemia .... ☐ Yes
Angina Pectoris .... ☐ Yes
Arteriosclerosis .... ☐ Yes
Arthritis .... ☐ Yes
Artificial Heart Valve .... ☐ Yes
Artificial Joints (hip, knee, etc.) .. ☐ Yes
Asthma .... ☐ Yes
Back Problems .... ☐ Yes
Bleeding abnormally with extractions or surgery .... ☐ Yes
Blood Transfusion .... ☐ Yes
Bowel Problems .... ☐ Yes
Brain Injury .... ☐ Yes
Bruise Easily .... ☐ Yes
Cancer .... ☐ Yes
Chemotherapy .... ☐ Yes
Chronic Cough .... ☐ Yes
Circulatory Problems .... ☐ Yes
Cold Sores/Fever Blisters .... ☐ Yes
Congenital Heart Disease .... ☐ Yes
Cortisone Medicine .... ☐ Yes
Developmentally Disabled .... ☐ Yes
Diabetes .... ☐ Yes

Drug Addiction .... ☐ Yes
Ear Aches .... ☐ Yes
Emphysema .... ☐ Yes
Epilepsy or Seizures .... ☐ Yes
Fainting or Dizzy Spells .... ☐ Yes
Glaucoma .... ☐ Yes
Hay Fever .... ☐ Yes
Headaches .... ☐ Yes
Hearing Loss .... ☐ Yes
Heart Condition .... ☐ Yes
Heart Disease or Attack .... ☐ Yes
Heart Failure .... ☐ Yes
Heart Murmur .... ☐ Yes
Heart Pacemaker .... ☐ Yes
Heart Surgery .... ☐ Yes
Hemophilia. .... ☐ Yes
Hepatitis A (infectious) .... ☐ Yes
Hepatitis B (serum) .... ☐ Yes
Hepatitis C .... ☐ Yes
Herpes .... ☐ Yes
High Blood Pressure .... ☐ Yes
H.I.V. Positive .... ☐ Yes
Hyperactivity .... ☐ Yes
Hypoglycemia .... ☐ Yes
Kidney Problems. .... ☐ Yes

Liver Disease .... ☐ Yes
Mitral Valve Prolapse .... ☐ Yes
Nervousness .... ☐ Yes
Psychiatric Care .... ☐ Yes
Radiation Therapy .... ☐ Yes
Respiratory Disease .... ☐ Yes
Rheumatic Fever .... ☐ Yes
Rheumatism .... ☐ Yes
Scarlet Fever .... ☐ Yes
Sexually Transmitted Disease ...... ☐ Yes
Sickle Cell Disease .... ☐ Yes
Sinus Problems .... ☐ Yes
Skin Rash .... ☐ Yes
Sore Throats .... ☐ Yes
Stroke .... ☐ Yes
Swollen Neck Glands .... ☐ Yes
Thyroid Problems .... ☐ Yes
Tonsillitis .... ☐ Yes
Tuberculosis .... ☐ Yes
Tumors .... ☐ Yes
Ulcers .... ☐ Yes
Venereal Disease .... ☐ Yes
Yellow Jaundice .... ☐ Yes
Does your child wear contact lenses? ☐ Yes

Please explain any of the above in detail: ______________________________

____

-NEXT PAGE-

G. Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Loniminm, Adipex, Fastin (brand names of phenetermine), Pondimin (fenfluramine) and Redux (dexefenfluramine). ❒ YES ❒ NO

H. Please describe any dental problems or special concerns you have with your child:

____

____

Doctor's Signature______________________________________ Date______________

I. Please list the names and phone numbers of family members or other people authorized by you to seek dental care, schedule appointments and make decisions regarding your child.

Name________________ Relationship to child________________ Phone ______________

Name________________ Relationship to child________________ Phone ______________

Name________________ Relationship to child________________ Phone ______________

V. CONSENT

I authorize the staff of *Children's Dental Center and Big People, Too!* to take X-Rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the staff to perform all mutually agreed upon treatment and to use those methods deemed appropriate in completing that treatment. I understand that I am financially responsible for the payment of all dental services at the time those services are rendered. I understand that if this office accepts my insurance company's assignment, I am still fully responsible for payment of those services. My insurance may not cover the services or may only partially cover them and any estimate given by this office is not a guarantee of actual payment by my insurance company. I also understand that I am responsible for missed appointment charges, collection costs and any financial charges.

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 payers and/or other health practitioners.

Patient Name______________________________________ Date ______________

Please Print Name:______________________ Signature______________________ Relationship __________

THANK YOU! We know it's a long form. This information is necessary to provide the BEST DENTAL CARE we can for your child!