Welcome

Patient Information

Date _____ S.S # _____ Birthdate _____ Age _____

Name of Minor/ Child _____ Sex ☐ Male ☐ Female
Last name First Name Middle Initial

Nick Name _____ Hobbies _____ Cell Phone( ) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone ( ) _____

Person Financially responsible _____ Home Phone( ) _____ Work Phone( ) _____

Whom may we thank for referring you? _____

Insurance Information (please provide insurance card)

Father's / Guardian's Name _____
Address(If different from patient's) _____

Cell Phone ( ) _____ Work Phone( ) _____
E-mail _____
Employer _____
S.S # _____ Birthdate _____
Do you have dental insurance coverage for minor/child ☐ Yes ☐ No
Name Of Insurance Company _____
Group # _____ Phone ( ) _____
Plan Name _____
Subscriber # _____

Mother's/ Guardian's Name _____
Address(If different from patient's) _____

Cell Phone ( ) _____ Work Phone( ) _____
E-mail _____
Employer _____
S.S # _____ Birthdate _____
Do you have dental insurance coverage for minor/child ☐ Yes ☐ No
Name Of Insurance Company _____
Group # _____ Phone ( ) _____
Plan Name _____
Subscriber # _____

DENTAL HISTORY

Date of last visit to dentist _____ For what service _____

	YES	NO		YES	NO
Has child complain about dental problems …	☐	☐	Is fluoride taken in any form……	☐	☐
Does child brush teeth daily……	☐	☐	Any injuries to mouth, teeth, head?..	☐	☐
Does child use floss every day ……	☐	☐	Any unhappy dental experiences?…..	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc.?				☐	☐

Medical History

Minor/child's Physician _____ City/State _____ Phone (___) _____

Date of last physical examination _____ Results _____

	YES	NO
Is minor/child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following, please check ☑

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problem	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

Emergency Contact

In the Event of an Emergency, whom should we contact?

Name _____ Relationship _____ Phone (_____) _____

Name _____ Relationship _____ Phone (_____) _____

Authorizations

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/ Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and release

I certify that my dependent(s), is covered by insurance with _____ and assign directly
Name of insurance company (ies)

to Friendship Smiles 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 authorize the use of my signature on all insurance submissions. The above-named office may use my minor/child's health care information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of parent, Guardian or Personal Representative Relationship to patient