UPDATED BY PATIENT	
1. ____/____/____	______
2. ____/____/____	______
Date	Pt's initials

OFFICE USE ONLY

	Date	Div I initials	Date	Div IV initials
1.	____/____/____	_____	____/____/____	______
2.	____/____/____	_____	____/____/____	______
3.	____/____/____	_____	____/____/____	______

OFFICE USE ONLY

Date _____/_____/_____

Acct. # _________________

CHILD PATIENT INFORMATION

Child's Full Name ____ _____/_____/_____ _____ ________
Last First Middle Name Birth Date Age Sex

Address ____ _____ ________
Number & street Apt # City State Zip Code

RESPONSIBLE PARTY

Name, Address, and Phone Number of person responsible for this child's account

____
Last First Middle Name Number & Street City State Zip Code

Responsible Party's Relationship to Child ______________________________E-mail address ________________________________

Responsible Party's Home Phone _____________________ Work Phone _______________________ Mobile Phone _____________________

Responsible Party's Social Security # ________/______/________

Responsible Party's Place and Address of Employment ____

Are Child's Parents: Married ________ Single ________ Divorced ________ Widowed ________ Separated ________

PARENT INFORMATION

Father's Name ____ Phone ______________________________

Address ____
(If same as above, please omit) Number & Street City State Zip Code

Mother's Name ____ Phone ______________________________

Address ____
(If same as above, please omit) Number & Street City State Zip Code

PARENT EMPLOYMENT

Father's Place of Employment ____ Position ___________________________

Length of Employment _________________ Address ____Phone_____________________

Mother's Place of Employment ____ Position ___________________________

Length of Employment _________________ Address ____ Phone_____________________

Child's Social Security # ____/_____/________ Father's _______/______/________ Mother's _______/______/________

Have other members of your immediate family been patients here before? ☐ Yes ☐ No Relationship ____________________________

Whom may we thank for referring you to our office? ____

Please list the name and phone number of a close friend or close relative **NOT RESIDING WITH YOU** who we may contact in case of an emergency or if we are unable to contact you.

____
Name Relationship Phone #

DENTAL INSURANCE

As a courtesy to you, we will file for primary dental insurance to your company. In order to do this, we must have one completed and signed form on file per patient **per calendar year**. If your insurance company has not remitted payment within 60 days of the date of service, the balance will be due and payable by the patient. Please complete the following information regarding dental insurance.

Primary **Dental** Insurance Company ______________________ Employer: ______________________ Employee: ______________________

Ins. Co. Mailing Address ____ Phone # ______________________

Employee S.S # _____/_____/_____ ID# ____________________ Group # __________________ Employee's Birth date: _____/_____/_____

OVER

CHILD'S DENTAL AND MEDICAL HEALTH

Is your child ALLERGIC to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Other medications (list)_______________________

Have you been told by a physician that your child needs an antibiotic premed before receiving any dental treatments? YES NO (please circle)

If yes, what medication is recommended by your doctor?_____________________ For what medical condition? _________________________

Please **CIRCLE** if your child has or has had any of the following:

Heart Murmur	Arthritis	Convulsions	Stroke	Fainting/Dizziness
Rheumatic Fever	Asthma	Jaundice	Ear/Eye/Nose/Throat Disorder	Thyroid Disease
Congenital Heart Lesion	Hepatitis	Sinus Trouble	Adrenal Disorders	Allergies
Heart Condition	Epilepsy	Kidney Trouble	Speech Problems	Hyperactivity
Blood Disease	Blood Transfusion	High Blood Pressure	Anemia	Diabetes
HIV Positive/Aids	Mental Retardation			

Has your child ever had any other serious illness not circled above? ☐ Yes ☐ No

Please describe in detail:____

1. Reason for child's visit today? ____
2. Child's Previous Dentist ____
   Name Address Phone
3. Child's Physician ____
   Name Address Phone

	Yes	No
4. Does your child drink fluoridated water? ………	☐	☐
5 . Is your child taking fluoride tablets / drops? ………	☐	☐
6. How often are your child's teeth brushed? ________________________________		
7. What type of toothpaste does your child use? ________________________________		
8. Does your child suck his thumb, finger, or lip? (circle which) ………	☐	☐
9. Has your child had problems with previous dental treatment?(Please describe) ____________________	☐	☐
10. Does your child have a dental condition about which you are especially concerned? ………	☐	☐
(If yes, describe this condition) ________________________________		
11. Is this your child's first visit to the dentist? ………	☐	☐
12. Has your child been under a physician's care or hospitalized within the last two years? ………	☐	☐
Please state reason ________________________________		
13. Has your child taken any prescription medication during the past year? Please list ____________________	☐	☐
14. Has your child had excessive bleeding requiring special treatment? ………	☐	☐
Please explain ________________________________		
15. Is your child subject to fainting spells? ………	☐	☐
16. Has your child had adverse effects from any dental anesthetic? ………	☐	☐

HIPPA (OPTIONAL)

I give my permission for the following person, ________________________________Relationship to child___________________________, to bring my child to dental appointments. This person also has my permission to update personal/medical history and to be involved in my child's dental information and treatment.

Signature (Parent/Guardian) ____Date ________________________

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Dr. Bentley and his Associates to discuss my conditions with my physician and to request medical information for him. I authorize the office of Mark T. Bentley, D.D.S., Inc. or his agent to obtain and verify a credit report. I understand that there will be a fee for any broken appointment or any appointment cancelled less than 24 hours, unless is an emergency.

CREDIT POLICY

A $25.00 rebilling fee will be charged for each month your balance is overdue. A balance is overdue if not paid within 60 days from the DATE OF SERVICE, regardless of insurance coverage. I understand that any legal fees incurred by this office in collection of the accounts balance will be my responsibility.

Signature (Parent/Guardian) ____

If you are completing this form for the child but are not the parent/guardian , Please sign below and indicate your relationship to the child.

____

Signature (grandparent, aunt, sister, etc.)