UPDATED BY PATIENT

1. ___/___/___ _____
2. ___/___/___ _____
Date Pt's initials

OFFICE USE ONLY

1. ___/___/___ _____ ___/___/___ _____
2. ___/___/___ _____ ___/___/___ _____
3. ___/___/___ _____ ___/___/___ _____
Date Div I initials Date Div IV initials

OFFICE USE ONLY

Date _____/_____/_____

Acct. # _____

Revised 12/30/2015

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? ……	☐	☐

Office Policy

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 48 hours advanced notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Confirming Your Appointment

Your time is valuable and ours is too. To that end, we ask that you confirm your appointment. You will receive a text or email message asking you to reply with a "C" to confirm. If you respond to that first message, you will not get another reminder until the day of your appointment. If you do not respond by 12:00pm the day before, you will lose that appointment.

Payment and Insurance Authorization

Payment in full for your treatment is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, Care Credit and assigned insurance benefits. Patients are responsible for any balance left on the account due to an insurance shortage or underpayment. If a balance is outstanding for more than 60 days, a $25.00 rebilling fee will be assessed for each month the balance is not paid. Payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

I authorize the office of Excellence in Dentistry to release any information relating to my insurance claim and I authorize payment from my insurance company to be made directly to Excellence in Dentistry. I authorize Excellence in Dentistry or their agents to obtain and verify a credit report. I also understand that all fees not paid by insurance are 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.)