Downtown Family Dental would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Thank you for selecting Downtown Family Dental for your dental healthcare team.

Today's Date_____

Patient Information (Confidential)

Name of Child_____
Last First Middle

Male____Female____Birthdate_____Social Sec. #_____Phone #_____

Child's Address_____
Street P.O. Box

_____
City State Zip Code

Hobbies_____

Contact Person in Case of Emergency_____

Whom May We Thank For Referring You?_____

Responsible Party/Insurance Information

Father/Guardian's Name_____

Address_____

Home Phone #_____

Work Phone # _____

Driver's License No._____

Birthdate_____SS#_____

Employer_____

Insurance Co._____

Group # _____

Mother/Guardian's Name_____

Address_____

Home Phone # _____

Work Phone # _____

Driver's License No._____

Birthdate_____SS#_____

Employer_____

Insurance Co._____

Group # _____

Medical History

Child's Physician_____

Telephone #_____

Date of last exam_____

	YES	NO
Is child under care of physician now?	____	____
Is child receiving any medications?	____	____
Has child ever been hospitalized?	____	____
Has child ever had surgery?	____	____
Are there any emotional problems?	____	____
Is child in good physical condition?	____	____
Is pre-medication recommended before dental treatment?	____	____
Is child allergic latex?	____	____

Medications Taken_____

_____

Medicine Allergies_____

_____

Has child had a history of or difficulty with any of the following?

____AIDS/HIV	____Cerebral Palsy	____Epilepsy
____Anemia	____ Chicken Pox	____Fainting
____Asthma	____ Convulsions	____Hearing
____Bladder	____ Diabetes	____Heart
____Cancer	____ Hepatitis	____Mumps
____Sinuses	____ Measles	____Mono
____Kidneys	____ Drugs/Alcohol	____Bleeding
____Liver	____ Malignancies	____Rheumatic Fever

Other (Please Explain)

_____

_____

_____

Dental History

Date of last dental visit_____

What was appt. for?_____

Any unhappy dental experiences? (Please explain)

_____

_____

Child's Attitude towardsdentistry?_____

Chief Dental Complaint_____

_____

	YES	NO
Has child complained about dental problems?	____	____
Does child brush/floss teeth daily?	____	____
Is fluoride taken in any form?	____	____
Has child had any injuries to mouth, teeth, or head?	____	____
Any mouth habits: thumbsucking, nail biting, mouth breathing, bottle/pacifier?	____	____

LATE CHARGES. If I do not pay the entire balance within 60 days of the date of service, a late charge of 1.5% monthly, 18% annually on the balance unpaid and owed will be accessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services.

Authorization & Release. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be harmful to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.
I authorize the dentist tom 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 payors and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my family.

Signed_____**Date**_____