Welcome Form (Minor)

Your Child

Child's Name _____
Nickname _____ Sex _____
Birth Date _____ Age _____
SS# / SIN _____
School _____ Grade ____
Child's Home Address _____
City _____ State ___ Zip _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State ___ Zip _____
Email _____
Phone _____ SS# / SIN _____
DL # _____

Who is responsible for making appointments?

Name _____
Home Phone _____ Cell _____
Work Phone _____ Ext. _____

Best time to call _____
Time _____ Day _____
_____

Mother ☐ Step Mother ☐ Guardian

Name _____
Home Phone _____ Cell _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS# / SIN _____ D.O.B. _____
DL # _____

Father ☐ Step Father ☐ Guardian

Name _____
Home Phone _____ Cell _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS# / SIN _____ D.O.B. _____
DL # _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Primary Insurance

Insured's Name _____
Relationship _____
SS# / SIN _____ D.O.B. _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City _____ State ___ Zip _____

Additional Insurance

Insured's Name _____
Relationship _____
SS# / SIN _____ D.O.B. _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. Address _____
City _____ State ___ Zip _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.
Payment in full at each appointment. □ Cash □ Personal Check Credit Card □Visa □MC □Discover □AMEX
□ I wish to discuss the office's payment policy.

Dental & Health *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____
How often does your child floss? _____
Is your child's water fluoridated? . . . . . □ Yes □ No
Does your child take fluoride supplements? □ Yes □No
Does your child:
Suck thumb/finger . . . . . □ Yes □ No
Grind teeth . . . . . □ Yes □ No
Suck/bite lip . . . . . □ Yes □ No
Clench jaws . . . . . □ Yes □ No
Bite/chew nails . . .. □ Yes □ No
Gag easily . . . . . □ Yes □ No
Chew hard objects (pencils, etc.). . . . . □ Yes □ No
Tonsils/Adenoids removed ___ age . . . . . □ Yes □ No
Speech Problem . . . . . □ Yes □ No

Previous dentist _____
Address _____
Date of last dental visit? _____
_____
Has your child had difficulty with previous dental visits?
□ Yes □ No
Child's physician _____
Address _____
Phone # _____
_____
Previous Hospitalizations/Surgeries/Serious Illnesses?
When?
_____
_____
_____
_____
_____

Is your child taking medications? □ Yes □ No
(If yes, please list) _____
Does your child have a history of allergies/sensitivities /adverse reactions to any drugs or medications? (penicillin, Novocain, etc.?) □ Yes □ No
(If yes, please describe) _____
Does your child have a history of allergies to any other substances (latex, environmental, etc.)? □ Yes □ No
_____
_____

Has your child ever had any of the following:
Acid Reflux . . . . . □ Yes □ No
Heart Problems . . . . . □ Yes □ No
Anemia . . . . . □ Yes □ No
Describe _____
Asthma . . . . . □ Yes □ No
_____
Blood Transfusion . . . . . □ Yes □ No
Hemophilia/Abnormal Bleeding . . . . . □ Yes □ No
Cancer . . . . . □ Yes □ No
Hepatitis . . . . . □ Yes □ No
Convulsions/Epilepsy. . . . . □ Yes □ No
HIV/AIDS . . . . . □ Yes □ No
Diabetes . . . . . □ Yes □ No
Persistent Cough . . . . . □ Yes □ No
Food Allergies . . . . . □ Yes □ No
Rheumatic Fever . . . . . □ Yes □ No
Handicaps/Disabilities . . . . . □ Yes □ No
Stomach, liver or kidney problems. . . . . □ Yes □ No
Hearing Impairment . . . . . □ Yes □ No
Heart Problems . . . . . □ Yes □ No

Please explain any medical problem that your child has: _____
_____

Authorization & Release

□ I understand that providing incorrect information can be dangerous and it is my responsibility to inform the office of any changes in the child's medical status. I also authorize the staff to perform the necessary services the child may need.

□ I also authorize the release of any information including the diagnosis and the records of treatment or examination rendered, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carriers may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

X_____

Signature of parent/guardian Date