

**Dentistry for Children and Young Adults**

PATIENT INFORMATION

NAME	SEX	DOB	AGE
ADDRESS	CITY	ZIP	
PHONE	CELL #		
OTHER FAMILY MEMBERS SEEN IN OUR OFFICE			
NAME OF PREVIOUS DENTIST	LAST DENTIST VISIT		
PERSON TO CONTACT IN CASE OF EMERGENCY			
HOW DID YOU HEAR ABOUT OUR OFFICE?			
PARENT'S NAME			
ADDRESS (IF DIFFERENT FROM ABOVE)			
MARITAL STATUS	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED

PRIMARY INSURANCE

ADDITIONAL INSURANCE

INSURED'S NAME	SECONDARY – INSURED'S
INSURANCE CO.	INSURANCE CO.
ADDRESS	ADDRESS
GROUP #	GROUP #
ID #	ID #

EMPLOYMENT

NAME OF EMPLOYEE	DOB	NAME OF EMPLOYEE	DOB
EMPLOYER NAME & ADDRESS		EMPLOYER NAME & ADDRESS.	
UNION OR LOCAL #		UNION OR LOCAL #	
* EMPLOYEE SS #		EMPLOYEE SS #	
WORK PHONE #		WORK PHONE #	

\* If SS # is not given, cash only will be required at the time of services. INSURANCE CLAIMS will be submitted providing ALL pertinent information is provided to our office. Upon payment of the claim by the insurance company, the responsible party will be billed for the account balance. However, the RESPONSIBLE PARTY WILL BE HELD ACCOUNTABLE FOR ALL FEES, regardless of insurance coverage. Accounts are due in full upon receipt of statement, unless prior financial arrangements have been made. Upon receipt of insurance payment, finance charges are accrued on accounts at a rate of 1% a month.

\*\* PLEASE NOTE THE PERSON BRINGING A CHILD IN FOR TREATMENT WILL BE CONSIDERED THE RESPONSIBLE PARTY AND WILL BE BILLED AS SUCH. OUR OFFICE WILL NOT BILL ANY OTHER PARTY.

I agree to the financial terms as stated above:

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Does your child have or, ever had, any of the following treatments or conditions:

	YES	WHEN?	NO	UNSURE		YES	WHEN?	NO	UNSURE
Anemia					Heart Condition/Murmur				
Asthma					Hepatitis				
Attention Deficit Disorder					HIV (Aids)				
Behavior Counseling					Hypertension				
Birth Defects					Kidney Disease				
Cancer					Mental Retardation				
Cerebral Palsy					Psychiatric Problems				
Delayed Speech Development					Rheumatic Fever				
Diabetes					Sickle Cell Anemia				
Epilepsy/Seizures					Xray Treatment (non-dental)				
Hearing Loss/Impairment									

Are there any Conditions other than those mentioned above that we should be aware of?

1. Is your child allergic to any medications or foods?
2. Is your child currently taking any medications/ what for?
3. Has your child ever been hospitalized / what for?
4. Has your child ever had difficulty with general anesthesia / describe?
5. Have any relatives ever had difficulty with general anesthesia / describe?

**DENTAL HISTORY**

Date of last visit to dentist
What was child treated for (i.e., cleaning, xrays, fillings, etc.)
Any injuries to mouth, teeth or head
Oral habits (i.e., thumb sucking, pacifiers, nursing, bottle, etc.)
Has your child had previous dental xrays/ with whom? <span style="float: right;">Phone #</span>
Do you live in an area with fluoridated water?
Does your child currently take fluoride supplements?
Has your child had any unhappy dental experiences? Please explain
Child's Physician <span style="float: right;">Phone #</span>
Last Physical Exam

**INFORMED CONSENT**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize Dr. Atherton and the dental staff under his direction to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist group insurance benefits otherwise payable to me.

Signature of Parent or Guardian

Date \_\_\_\_\_