Patient Information Form – Minor / Child

Date					
Name				Nickname	
Address					
City				State	Zip
☐ Male	☐ Female	Birthday	Age	Hobbies	
Whom can we thank for referring you?					
Notify in case of Emergency			Relationship to the patient		
Home Phone		Work		Cell	
Father's name			Date of Birth		
Address (if different from Patient)					
City				State	Zip
Home Phone		Work		Cell	
Employer				Soc. Sec#	
Do you have Dental Insurance coverage for minor/child? ☐ yes ☐ no					
Insurance Company			Phone:		
Subscriber #		Group #		Contract#	
Mother's name			Date of Birth		
Address (if different from Patient)					
City				State	Zip
Home Phone		Work		Cell	
Employer				Soc. Sec#	
Do you have Dental Insurance coverage for minor/child? ☐ yes ☐ no					
Insurance Company			Phone:		
Subscriber #		Group #		Contract#	

Dental History	
Former Dentist	Phone
Date of last visit	For what service?
Has child complained about dental problems?	
Does child brush teeth daily?	Does child floss daily?
Is fluoride taken in any form?	Any injuries to mouth, teeth, or head?
Any unhappy dental experiences?	
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	

Medical History	
Physician's Name	Phone
Date of last Visit	Results?
Is child under care a physician now?	Receiving any medication or drugs?
Ever been hospitalized?	Ever had surgery?
List all current medications:	
List any allergies:	

Has minor/child had any history of or difficulty with any of the following? (Please check)

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Cancer
- ☐ Cerebal Palsy
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rheumatic / Scarlet Fever
- ☐ Sinus Problems
- ☐ Thyroid disease
- ☐ Tuberculosis

☐ Other items, please list:

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental service for my minor/child.

Signature: ____ Date ______________

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: ____ Date ______________

Payment is due in full at time of treatment, unless prior arrangements have been approved.