

PATIENT INFORMATION

Child's Full Name: _____

DOB: _____ Preferred name: _____

School: _____ Grade: _____

Sex: Male Female Hobbies/favorite toys: _____

How did you hear about us?

TV Radio Magazine Facebook Website School/Daycare My Base Guide

FAMILY INFORMATION

Mother/Guardian

Father/Guardian

Last Name First Name MI

Last Name First Name MI

Street Address City, State, Zip

Street Address City, State, Zip

Home phone # Work phone #

Home phone # Work phone #

Cell phone # e-mail address (for reminders)

Cell phone # e-mail address (for reminders)

Birthdate (MM/DD/YY) SS#

Birthdate (MM/DD/YY) SS#

Employer

Employer

Drivers License # State

Drivers License # State

Parent/Guardian Status: Single Married Divorced Separated Widowed Foster Other: _____

Child lives with: Parents Mother Father Grandparents Foster Parents Other: _____

If divorced, are there court documents that require either parent to carry insurance on child: YES NO
(please provide copy)

If divorced, who has primary legal custody of this child? _____

Person to contact outside of immediate family in case of emergency: Name: _____

Address: _____ Phone: _____
Street Address City, State, Zip Home Alternate

INSURANCE INFORMATION

Primary Insurance

Secondary Insurance

Medical Insurance

Insured's Full Name/DOB

Insured's Full Name/DOB

Insured's Full Name/DOB

Employer

Employer

Employer

Insurance Company Name

Insurance Company Name

Insurance Company Name

Member ID # Group #

Member ID # Group #

Member ID # Group #

PATIENT'S DENTAL HISTORY

Has your child ever seen another dentist? YES NO

If yes to above, Dr Name: _____ Date of Last Visit: _____

Is your child currently seeing an orthodontist? YES NO

If yes to above, Dr Name: _____

Have your child's teeth ever been injured? YES NO

If yes to above, when: _____

Has your child sucked a thumb, finger or pacifier? YES NO

If yes to above, ages, when: _____

Do you think your child will react well to dental treatment? YES

Is your child currently breast feeding? YES NO Is your child currently bottle feeding? YES NO

Do you brush your child's teeth? YES NO Does your child brush their own teeth? YES NO

Does your child use dental floss YES NO Does your child use a sippy cup? YES NO

Please check if your child is having problems with any of the following:

Cavities	Color of teeth	Gum infections	Sensitive teeth
Toothache	Orthodontics	Jaw Pain	Mouth Sores

PATIENT'S MEDICAL HISTORY

Name of child's physician: _____ Phone #: _____

Date of last physical exam: _____

Has your child ever had a health problem? YES NO _____

Has your child had any operations/hospitalizations? YES NO _____

Is your child currently taking any medications? YES NO _____

Are your child's immunizations up to date? YES NO _____

Please check yes or no on all:

YES	NO	ADD/ ADHD	YES	NO	Fainting
YES	NO	AIDS/HIV	YES	NO	Heart Condition <i>(specify below)</i>
YES	NO	Allergies <i>(specify below)</i>	YES	NO	Hepatitis
YES	NO	Asthma	YES	NO	Kidney Condition
YES	NO	Autism	YES	NO	Liver Condition
YES	NO	Blood Disorder	YES	NO	Mental Disability
YES	NO	Cancer	YES	NO	Physical Disability
YES	NO	Cerebral Palsy	YES	NO	Cerebral Palsy
YES	NO	Developmental Delay	YES	NO	Sickle Cell
YES	NO	Diabetes	YES	NO	Seizures
YES	NO	Down Syndrome	YES	NO	Special Needs <i>(specify below)</i>
YES	NO	Epilepsy	YES	NO	Speech Problems
YES	NO	Eye Disease	YES	NO	Stomach/GI Disease
YES	NO	Ear Problems <i>(other than tubes)</i>	YES	NO	Tuberculosis
			YES	NO	Other: _____

If you checked yes to any of the above, please explain: _____

PATIENT'S MEDICAL HISTORY CONTINUED

Please check if your child is allergic to any of the following:

No Known Allergies	Latex	Metal	Acrylic	Local Anesthesia
Penicillin	Aspirin	Sulfa	Red dye	Other: _____

AUTHORIZATION STATEMENTS

_____ I do hereby authorize Dr. Schreiber, doctors and the staff of Dentistry for Children, PC to provide my child
(initial) with diagnostic and therapeutic procedures, including dental x-rays and photographs, as may be necessary
for proper dental care.

_____ I do hereby understand that dental treatment for children includes efforts to guide their behavior by
(initial) helping them to understand the treatment by using praise, explanation, and demonstration of procedures
and instruments using variable voice tones. I authorize this Dental Office to administer such medication,
including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety
and/or the use of a mouth prop.

_____ I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise
(initial) payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate
given to me is not guaranteed. I authorize the release of any information relative to all claims. The
undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of
collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim
exemption under the constitution and laws of the State of Alabama or any other state.

_____ I acknowledge that my copay is expected at the time of service and that any unpaid copay is subject to a
(initial) \$20.00 fee and, after 90 days, a monthly billing fee of \$2.00

_____ I acknowledge that a fee of \$35 for missed or canceled appointments without a 24 hour notification.
(Initial)

_____ I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Insurance
(initial) Portability & Accountability act of 1996 (HIPAA), and have been offered a copy of it.

I AGREE and grant full permission for Dentistry for Children to use either myself or my child's **first name &**
OR **photograph** in any publication or advertising materials (printed or electronic). This consent always
waives the rights of privacy or compensation for the use of photo or name.

I AGREE and grant full permission for Dentistry for Children to use either myself or my child's **photograph only,**
OR in any publication or advertising materials (printed or electronic). This consent always waives the rights
of privacy or compensation for the use of photo.

I DO NOT AGREE to have mine or my child's information or photograph used.

Whom may we release information to? _____

The information on this page, including the medical history, is correct to the best of my knowledge. I understand
that if any of the above information changes, including medical history, that it is my responsibility to inform this
Dental Office.

Signature of: Mother Father Grandparent Guardian

Date