PATIENT INFORMATION

Child's Full Name: _____

DOB: _____ Preferred name: _____

School: _____ Grade: _____

Sex: ☐ Male ☐ Female Hobbies/favorite toys: _____

How did you hear about us? ☐ Dr. _____ ☐ Friend/Family _____ ☐ Other _____

☐ 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 AIDS/HIV

☐YES ☐NO Allergies *(specify below)*

☐YES ☐NO Asthma

☐YES ☐NO Autism

☐YES ☐NO Blood Disorder

☐YES ☐NO Cancer

☐YES ☐NO Cerebral Palsy

☐YES ☐NO Developmental Delay

☐YES ☐NO Diabetes

☐YES ☐NO Down Syndrome

☐YES ☐NO Epilepsy

☐YES ☐NO Eye Disease

☐YES ☐NO Ear Problems *(other than tubes)*

☐YES ☐NO Fainting

☐YES ☐NO Heart Condition *(specify below)*

☐YES ☐NO Hepatitis

☐YES ☐NO Kidney Condition

☐YES ☐NO Liver Condition

☐YES ☐NO Mental Disability

☐YES ☐NO Physical Disability

☐YES ☐NO Sickle Cell

☐YES ☐NO Seizures

☐YES ☐NO Special Needs *(specify below)*

☐YES ☐NO Speech Problems

☐YES ☐NO Stomach/GI Disease

☐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 & 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.

OR

☐ **I AGREE** and grant full permission for Dentistry for Children to use either myself or my child's ***photograph only***, 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

☐ **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*