

PATIENT INFORMATION

Child's Full Name: _____ DOB: _____ Preferred name: _____
First Middle Last

School: _____ Grade: _____ Sex: M/F Hobbies/favorite toys: _____

Have we treated anyone in your family? Yes No If yes, whom? _____

How did you hear about us? TV Radio Magazine Facebook Website School/Daycare My Base Guide
 Dr. _____ Friend/Family: _____ Other: _____

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 (circle): *Single Married Divorced Separated Widowed Foster Other:* _____

Child lives with (circle): *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 phone Alternate phone

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

MEDICAL INSURANCE

Insured's full name/date of birth

Insured's full name/date of birth

Insured's full name/date of birth

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

Yes No Has your child ever seen another dentist? Dr. _____ Date of last visit? _____

Yes No If yes to the above question, were x-rays taken? Bitewings? _____ Pan? _____

Yes No Is your child currently seeing an orthodontist? (if yes, Doctor's Name) _____

Yes No Have your child's teeth ever been injured (If yes, when)? _____

Yes No Has your child sucked a thumb, finger or pacifier? Ages, when? _____

Yes No Do you think your child will react well to dental treatment? _____

Yes No 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 his/her own teeth?

Yes No Does your child use dental floss? Yes No Does your child use a sippy cup?

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 Name: _____

PATIENT'S MEDICAL HISTORY

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

Date of last physical exam: _____

Yes No 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? _____

PLEASE CHECK YES OR NO ON ALL:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No ADD/ADHD (<i>circle one</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Condition (<i>specify below</i>) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies (<i>specify below</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Condition |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Condition |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Disability |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Physical Disability |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Developmental delay | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Special Needs (<i>specify below</i>) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Down Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach/GI Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eye disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear problems (<i>other than tubes</i>) | |

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

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 with
(initial) 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 helping them to
(initial) 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 payable to me. I
(initial) 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, a reasonable attorney fee of 33.33% and court costs, 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 \$20.00 fee and, after
(initial) 90 days, a monthly billing fee of \$2.00, and a fee of \$35 for missed or canceled appointments without a 24 hour notification.

_____ I acknowledge that this Dental Office may contact me by any phone, including wireless calls or texts which may incur a fee,
(initial) or email provided to collect monies I may owe.

_____ I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Insurance Portability &
(initial) 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.

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 (*circle one*): Mother Father Grandparent Guardian

Date