## PATIENT INFORMATION

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

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

## FAMILY INFORMATION

### MOTHER/GUARDIAN

_____
*Last Name First Name MI*

_____
*Street Address City, State, Zip*

_____
*Home phone # Work phone #*

_____
*Cell phone # e-mail address (for reminders)*

_____
*Birthdate (MM/DD/YY) SS#*

_____
*Employer*

_____
*Drivers License # State*

### FATHER/GUARDIAN

_____
*Last Name First Name MI*

_____
*Street Address City, State, Zip*

_____
*Home phone # Work phone #*

_____
*Cell phone # e-mail address (for reminders)*

_____
*Birthdate (MM/DD/YY) SS#*

_____
*Employer*

_____
*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 seen another dentist since the last visit with us? Dr._____
Phone #: _____ Date of last appointment: _____
☐ Yes ☐ No Is your child currently seeing an orthodontist? (if yes, Doctor's Name)_____
☐ Yes ☐ No If yes to either of the above questions, were x-rays taken? Bitewings: _____ Panoramic:_____

**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:

☐ Yes ☐ No ADD/ADHD *(circle one)*
☐ 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 Emotional Problems
☐ 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 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

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

_____ *(initial)* I do hereby understand that dental treatment for children includes efforts to guide their behavior by 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.

_____ *(initial)* I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise 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.

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

☐ **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 (circle one): Mother Father Grandparent Guardian* *Date*