**BEFORE FILLING OUT, YOU MUST: *Computer Users: Open PDF in Acrobat **Mobile Users: 1. Download Adobe Acrobat Reader app. 2. Import to Acrobat. 3. Fill & Sign**

## 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

*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

*Insured's full name/date of birth*

*Employer*

*Insurance Company Name*

*Member ID #* *Group #*

### SECONDARY INSURANCE

*Insured's full name/date of birth*

*Employer*

*Insurance Company Name*

*Member ID #* *Group #*

### MEDICAL INSURANCE

*Insured's full name/date of birth*

*Employer*

*Insurance Company Name*

*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:**

☐ 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, 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.

______ *(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 and, 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 this Dental Office may contact me by any phone, including wireless calls or texts which may incur a fee, or email provided to collect monies I may owe.

______ *(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.

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*

**Click SUBMIT button to send your completed form to our office (this button only works in Acrobat).**
**If you're having problems, you can email this PDF to info@chew-chewtrain.com**