CHILD FORM

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date ______________________

Name of Minor/Child ____
Last Name First Name Initial

Sex ❑ M ❑ F Age _________ Birth date ______________ Nick Name ___________________________ Hobbies ______________________________

Home Address ____
Street City State Zip

Mailing Address ____
Street City State Zip

Person financially responsible ____________________________________ Home Phone ______________________ Work Phone ______________________

Business Address____ Business Phone ______________________________

Whom may we thank for referring your child? ____

INSURANCE

Father's/Guardian's Name ____

Address (If different from patient's) ________________________________

____

Home Phone ____________________ Work Phone ____________________
(if different from above) (if different from above)

Employer____

Soc. Sec. # ________________________________ Birth date ____________

Dental insurance coverage for minor/child? ❑ Yes ❑ No

Plan Name ____

Phone Number ____

Address ____

Group # ____

Policy # ____

Mother's/Guardian's Name ____

Address (If different from patient's) ________________________________

____

Home Phone ____________________ Work Phone ____________________
(if different from above) (if different from above)

Employer____

Soc. Sec. # ________________________________ Birthdate____________

Dental insurance coverage for minor/child? ❑ Yes ❑ No

Plan Name ____

Phone Number ____

Address ____

Group # ____

Policy # ____

AUTHORIZATION

I certify that my minor/child is covered by insurance with ____
Name of Insurance Company(ies)

and assign directly to Dr. Richard M. Delano III all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian ____ Date ______________________

PLEASE COMPLETE BOTH SIDES

dental alternatives

CHILD FORM *(continued)*

DENTAL HISTORY

Date of last visit to a dentist For what service? ______________________________

Check ❑ if you your child has had problems with any of the following:

❑ YES ❑ NO Has child complained about dental problems?

❑ YES ❑ NO Does child brush teeth daily?

❑ YES ❑ NO Does child use floss everyday?

❑ YES ❑ NO Is fluoride taken in any form?

❑ YES ❑ NO Any injuries to mouth, teeth, head?

❑ YES ❑ NO Any unhappy dental experiences?

Any mouth habits? ❑ Thumb sucking ❑ Nail biting ❑ Mouth breathing ❑ Pacifier ❑ Sleeping with bottle, etc.

MEDICAL HISTORY

Minor/Child's Physician ______________________ City/State ______________________ Phone ______________________

Date of last physical examination ______________ Results ______________________________

Is Minor/Child under care of physician now? ❑ YES ❑ NO ______________________________

Receiving any medication or drugs? ❑ YES ❑ NO If yes, list ______________________________

Ever been hospitalized? ❑ YES ❑ NO If yes, list ______________________________

Ever had surgery? ❑ YES ❑ NO Allergies to medications? ______________________________

Is there excessive bleeding when cut? ❑ YES ❑ NO Allergies to latex, metals, anesthetics? ______________________________

Has Minor/Child had any history of or difficulty with any of the following? If yes, please check (✓):

❑ AIDS/HIV

❑ Anemia

❑ Asthma

❑ Cancer (Type______________________)

❑ Cerebral Palsy

❑ Convulsions

❑ Diabetes

❑ Drug/Alcohol Abuse

❑ Tobacco

❑ Epilepsy

❑ Fainting

❑ Hearing Problems

❑ Heart Problems (Type______________________)

❑ Hepatitis (Type______________________)

❑ Herpes (cold sores)

❑ Kidney Disease

❑ Liver Disease

❑ Sinus Problems

❑ Thyroid Disease

❑ Tuberculosis

❑ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? ______________________________

Name ______________________ Relationship ______________________ Phone______________________

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian ______________________________ Date: ______________