



CHILDREN'S DENTAL
Village



**Understanding
children's dental
needs begins with
understanding
children.**

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Welcome to our office!

The following information is for our records only, and will be considered confidential. Thank you for filling out **both sides** of this form completely ... it will help us give your child the best dental care possible.

DATE _____

••• CHILD'S FULL LEGAL NAME _____ LAST NAME _____ NICKNAME _____
ADDRESS _____ CITY, STATE, ZIP _____
PHONE _____ CHILD'S SOCIAL SECURITY NO. _____

FAMILY E-MAIL ADDRESS _____

MALE FEMALE AGE _____ BIRTHDATE _____ WEIGHT _____

NAME AND AGE OF SISTER(S) _____

NAME AND AGE OF BROTHER(S) _____

CHILD'S PHYSICIAN _____ PHYSICIAN'S PHONE _____

NAME OF ADULT ACCOMPANYING CHILD TODAY ? _____ RELATIONSHIP TO CHILD _____

••• FATHER'S LEGAL NAME _____ EMPLOYER _____ BUSINESS PHONE _____
OCCUPATION _____ HOW LONG? _____ BIRTHDATE _____
FATHER'S SOCIAL SECURITY NUMBER _____
SPOUSE'S NAME _____

••• MOTHER'S LEGAL NAME _____ EMPLOYER _____ BUSINESS PHONE _____
OCCUPATION _____ HOW LONG? _____ BIRTHDATE _____
MOTHER'S SOCIAL SECURITY NUMBER _____
SPOUSE'S NAME _____

••• PARENT MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED
PERSON RESPONSIBLE FOR ACCOUNT IS PARENT CHILD LIVES WITH. WHO IS THAT ? _____
ADDRESS _____ CITY, STATE, ZIP _____
PHONE _____

••• PRIMARY DENTAL INSURANCE CO. _____ SECONDARY DENTAL INSURANCE CO. _____
THEIR PHONE _____ THEIR PHONE _____
INSURED'S NAME _____ INSURED'S NAME _____
RELATIONSHIP TO CHILD _____ RELATIONSHIP TO CHILD _____
INSURED'S I.D. # _____ INSURED'S I.D. # _____
EMPLOYER _____ EMPLOYER _____
GROUP # _____ GROUP # _____
EFFECTIVE DATE _____ EFFECTIVE DATE _____

► **OVER, PLEASE**

BECAUSE CONDITIONS IN THE MOUTH CAN BE HEREDITARY, IT IS IMPORTANT TO KNOW IF YOUR CHILD IS ADOPTED. YES NO

IF YES, DOES HE/SHE KNOW ? _____

IS YOUR CHILD ALLERGIC TO, OR HAD ANY UNFAVORABLE REACTIONS TO DRUGS, INCLUDING ANTIBIOTICS AND LOCAL ANESTHETIC SOLUTIONS ?

YES NO IF YES, WHICH ONES ? _____

IS YOUR CHILD TAKING ANY MEDICATION AT THE PRESENT TIME ? YES NO IF YES, WHICH ONES AND WHAT FOR ? _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED ? YES NO IF YES, WHEN AND FOR WHAT REASON ? _____

IF YOUR CHILD HAS, OR HAS HAD, ANY OF THE FOLLOWING, PLEASE CHECK:

- ALLERGIES TO MEDICATIONS RHEUMATIC FEVER BLEEDING DISORDER/PROFUSE BLEEDING OTHER _____
- SEIZURES HEART PROBLEMS HEPATITIS _____
- BRAIN INJURY EPILEPSY TUBERCULOSIS _____
- CEREBRAL PALSY LIVER DISORDER PHYSICAL HANDICAP _____
- KIDNEY DISORDER DIABETES LEARNING DISABILITIES _____
- HIV+/AIDS ASTHMA SPECIAL NEEDS _____

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS REQUIRING ANTIBIOTICS FOR DENTAL TREATMENT ?

YES NO IF YES, WHAT IS THE CONDITION? _____

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT SURGERIES, SPECIAL NEEDS OR ANY OTHER MEDICAL INFORMATION WE SHOULD BE AWARE OF THAT HAS NOT YET BEEN DISCUSSED: _____

IS YOUR CHILD TAKING ANY FORM OF FLUORIDE (TABLETS, DROPS, MOUTH RINSES OR GELS) ? YES NO IF YES, WHICH ONES ? _____

DOES YOUR CHILD HAVE ANY THUMB SUCKING, FINGER SUCKING, LIP SUCKING, NAIL BITING, NURSING BOTTLE OR PACIFIER HABITS ?

YES NO IF YES, DESCRIBE: _____

HAS YOUR CHILD HAD ANY UNFAVORABLE EXPERIENCES IN A DENTAL OFFICE ? YES NO IF YES, DESCRIBE: _____

HAS YOUR CHILD RECEIVED ANY INJURIES TO THE MOUTH OR TEETH ? YES NO IF YES, WHEN _____

HAS YOUR CHILD HAD A TOOTHACHE RECENTLY ? YES NO IF YES, SPECIFY AREA _____

HAS YOUR CHILD BEEN TO THE DENTIST BEFORE ? YES NO IF YES, WHERE AND WHEN ? _____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE ? _____

DO YOU HAVE ANYTHING YOU WISH TO DISCUSS WITH THE DOCTOR TODAY ? _____

I HEREBY GIVE MY PERMISSION TO ADMINISTER TREATMENT, AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID MINOR CHILD.

I UNDERSTAND THAT THESE TREATMENTS WILL NOT BE RENDERED WITHOUT MY INFORMED CONSENT.

SIGNATURE OF PARENT OR GUARDIAN

DATE _____

I AM NOT ACCOMPANYING MY CHILD. I HAVE ATTACHED A PERMISSION SLIP AND THE NAME OF THE ADULT ACCOMPANYING MY CHILD.

.....

I AGREE TO PAY FOR SERVICES RENDERED IN THE FOLLOWING WAY:

CASH / CHECK / VISA
MASTERCARD OR
DISCOVER CARD AT
THE TIME OF TREATMENT.

I REQUEST OTHER FINANCIAL ARRANGEMENTS. THIS WOULD INCLUDE USING MY DENTAL INSURANCE. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE OF PARENT OR GUARDIAN

DATE _____