Welcome to our office!

CHILDREN'S DENTAL
Village
7360 S. McClintock Drive
Tempe, AZ 85283
480.838.6949

The following information is for our records only and will be considered confidential.
Thank you for completing **both sides**… it will help us provide the best dental care possible.

Date: ______________________

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Patient's Legal Name (First, MI, Last): ______________________ Preferred Name: ______________________

Gender: ❑ Male ❑ Female Age: __________ Date of Birth: ______________ Weight: __________

Address: ______________________ Apt#: ______ City, State Zip: ______________________

Home Phone: ______________________ Family Email Address: ______________________

Name / Ages of other children in family: ______________________

Patient's Physician: ______________________ Physician's Phone: ______________________

Name of adult(s) accompanying patient today? ______________________ Relationship to Patient: ______________________

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Person financially responsible for account is the person the patient lives with, accompanies the patient to most appointments and makes treatment decisions.

Responsible Party / Parent / Guardian Name: ______________________ Date of Birth: ______________________

Home Address: ______________________ Apt#: ______ City, State Zip: ______________________

Cell Phone: ______________ Email Address: ______________________ SS#: ______________________

Employer: ______________________

Relationship to Patient: ❑ Mother ❑ Father ❑ Step Parent ❑ Grandparent ❑ Legal Guardian

Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Separated ❑ Divorced ❑ Widowed Spouse's Name: ______________________

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Other Parent / Guardian Name: ______________________ Date of Birth: ______________________

Home Address: ______________________ Apt#: ______ City, State Zip: ______________________

Cell Phone: ______________ Email Address: ______________________ SS#: ______________________

Employer: ______________________

Relationship to Patient: ❑ Mother ❑ Father ❑ Step Parent ❑ Grandparent ❑ Legal Guardian

Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Separated ❑ Divorced ❑ Widowed Spouse's Name: ______________________

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Primary Dental Insurance Co: ______________________
Their Phone: ______________________
Insured's Name: ______________ DOB: __________
Relationship to Patient: ______________________
Insured's ID #: ______________________
Employer: ______________________
Group #: ______________________
Effective Date: ______________________

Secondary Dental Insurance Co: ______________________
Their Phone: ______________________
Insured's Name: ______________ DOB: __________
Relationship to Patient: ______________________
Insured's ID #: ______________________
Employer: ______________________
Group #: ______________________
Effective Date: ______________________

➤ **OVER PLEASE**

Because conditions of the mouth can be hereditary, it is important to know if the patient is adopted. ❑ Yes ❑ No
If yes, does he/she know? ❑ Yes ❑ No

Is patient allergic to or had any unfavorable reactions to drugs, including antibiotics and local anesthetic solutions? ❑ Yes ❑ No
If yes, which ones? ______________________________ Latex Allergy? ❑ Yes ❑ No

Is patient taking any medication at the present time? ❑ Yes ❑ No If yes, which ones and what for? ______________________________
____

Has the patient ever been hospitalized? ❑ Yes ❑ No If yes, when and for what reason? ______________________________
____

If patient has had any of the following please check:

❑ Allergies to medications	❑ Diabetes	❑ Learning disabilities	❑ Tree nut allergy
❑ Asthma	❑ Epilepsy	❑ Liver disorder	❑ Tuberculosis
❑ Autism Spectrum Disorder	❑ Heart problems	❑ Physical Handicap	❑ Other Special Needs: ______
❑ Bleeding disorder/Profuse bleeding	❑ Hepatitis	❑ Rheumatic Fever	______________
❑ Brain injury	❑ HIV+/AIDS	❑ Seizures	______________
❑ Cerebral Palsy	❑ Kidney disorder	❑ Snoring/Sleep Apnea	______________

Does the patient have any medical conditions requiring antibiotics for dental treatment? ❑ Yes ❑ No
If yes, what is the condition? ______________________________

Please describe any current medical treatment including medications, pending surgery, recent surgeries, special needs or any other medical information we should be aware that has not yet been discussed: ______________________________
____

Is the patient taking any form of fluoride (tablets, drops, mouth rinses or gels)? ❑ Yes ❑ No
If yes, which ones? ______________________________

Does the patient have any thumb sucking, finger sucking, lip sucking, nail biting, nursing, bottle or pacifier habits? ❑ Yes ❑ No
If yes, please describe: ______________________________

Has the patient had any unfavorable experiences in a dental office? ❑ Yes ❑ No
If yes, please describe: ______________________________

Has the patient received any injuries to the mouth or teeth? ❑ Yes ❑ No If yes, when? ______________________________
Has the patient has a toothache recently? ❑ Yes ❑ No If yes, specify area: ______________________________
Has the patient 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 patient.

I understand that these treatments will not be rendered without my informed consent.

____
Signature of Parent/Guardian

Date: ______________________________

❑ I am not accompanying the patient. I have attached a permission slip and the name of the adult accompanying him/her.

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I agree to pay for services rendered in the following way:

❑ Cash/Check/Credit or Debit 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 my be obtained.

____
Signature of Parent/Guardian

Date: ______________________________