

Patient Information

DATE _____

PATIENT NAME (last name, first name, middle name) _____

NICKNAME _____ BIRTH DATE _____ AGE _____ WEIGHT _____ MALE FEMALE ADOPTED

HOME PHONE _____ WORK PHONE (+ext.) _____ BEST TIME TO CALL _____

ADDRESS (street, apartment #) _____

CITY _____ STATE _____ ZIP CODE _____

BEST CONTACT PHONE NUMBER _____

Health Information

Date of last dental visit: _____ Reason for this visit: _____

Has your child ever had any of the following? Please check those that apply:

<input type="radio"/> ADD/ADHD	<input type="radio"/> Excessive bleeding	<input type="radio"/> Sensory Integration
<input type="radio"/> AIDS/HIV positive	<input type="radio"/> Eye/vision problems	<input type="radio"/> Stomach problems/ulcers
<input type="radio"/> Allergies or drug reactions	<input type="radio"/> Headaches	<input type="radio"/> Stroke
<input type="radio"/> Anemia	<input type="radio"/> Heart disease	<input type="radio"/> Tuberculosis
<input type="radio"/> Anxiety disorders	<input type="radio"/> Heart murmur	<input type="radio"/> Penicillin allergy
<input type="radio"/> Arthritis	<input type="radio"/> Hepatitis/jaundice	<input type="radio"/> Other medical problems: _____
<input type="radio"/> Artificial joints	<input type="radio"/> High/low blood pressure	
<input type="radio"/> Asthma/respiratory problems	<input type="radio"/> Latex allergy	Dental History
<input type="radio"/> Autism/PDD/OCDorsimilar	<input type="radio"/> Kidney disease	<input type="radio"/> Oral Habits: Thumb sucking, Pacifier, tongue thrusting, teeth grinding, cheek biting, nail biting,
<input type="radio"/> Blood disease/disorders	<input type="radio"/> Learning disabilities	<input type="radio"/> Injury to teeth or mouth
<input type="radio"/> Blood transfusion	<input type="radio"/> Liver disease	<input type="radio"/> Swelling or lumps in mouth
<input type="radio"/> Cancer/tumors/cysts	<input type="radio"/> Measles/mumps	<input type="radio"/> Blisters or sores in mouth or on lips
<input type="radio"/> Cerebral Palsy	<input type="radio"/> Nervous disorders	<input type="radio"/> Teeth extracted
<input type="radio"/> Depression	<input type="radio"/> Radiation treatment	<input type="radio"/> Pain around ears or jaw
<input type="radio"/> Diabetes	<input type="radio"/> Rheumatic fever	<input type="radio"/> Bleeding or sore gums
<input type="radio"/> Ear infections/problems	<input type="radio"/> Sickle cell	<input type="radio"/> Bedtime bottle or nursing
<input type="radio"/> Eating disorders	<input type="radio"/> Sinus problems	
<input type="radio"/> Endocrine/glandular problems	<input type="radio"/> Psychological Disorders	
<input type="radio"/> Epilepsy/seizures		

Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No. If yes, please explain: _____

Has your child ever had surgery? Yes No. If yes, please explain: _____

Is your child now under the care of a physician for anything other than routine care? Yes No. If yes, please explain on back of form.

Name of treating physician: _____ phone: _____

Name of pediatrician: _____ phone: _____ Date of last physical: _____

Does your child have any health problems that need further clarification? Yes No. If yes, please explain: _____

Is your child taking any medications? Yes No. If Yes, which ones? _____

How does your child feel about visiting the physician? _____

Has your child ever had any complications following dental treatment? Yes No. If yes, please explain: _____

Do you anticipate your child having difficulty accepting dental treatment? _____

Did your child breast feed? Yes No. Until what age? _____ Did your child drink a bottle? Yes No. Until what age? _____

Were there any problems or complications during pregnancy or delivery? Yes No. If yes, please explain: _____

Is your child up to date on his/her immunizations? Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any change in his/her health, I will inform the doctors at the next appointment without fail.

SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____

Whom may we thank for referring you to our practice?

Another patient friend relative dental office yellow pages internet school work

Name of person(s) or office referring you to our practice: _____

Responsible Party Info

PARENT/GUARDIAN 1 NAME	PARENT/GUARDIAN 2 NAME			
PARENT/GUARDIAN 1 SOCIAL SECURITY NUMBER	PARENT/GUARDIAN 2 SOCIAL SECURITY NUMBER			
PARENT/GUARDIAN 1 HOME PHONE	WORK PHONE (+ext.)			
PARENT/GUARDIAN 2 HOME PHONE	WORK PHONE (+ext.)			
PARENT/GUARDIAN 1 ADDRESS:	STREET	CITY	STATE	ZIP CODE
PARENT/GUARDIAN 2 ADDRESS:	STREET	CITY	STATE	ZIP CODE

Employment Info

PARENT/GUARDIAN 1 EMPLOYER NAME	PARENT/GUARDIAN 2 EMPLOYER NAME			
PARENT/GUARDIAN 1 OCCUPATION	PARENT/GUARDIAN 2 OCCUPATION			
PARENT/GUARDIAN 1 WORK ADDRESS:	STREET	CITY	STATE	ZIP CODE
PARENT/GUARDIAN 2 WORK ADDRESS:	STREET	CITY	STATE	ZIP CODE

Consent for Services

Payment is expected at the time of service and can be made by personal check, Visa, MasterCard, American Express or Discover.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1^{1/2}% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. There will be a \$25.00 charge for returned checks.

I understand that the fee estimate listed for this dental care can only be extended for a period of 60 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request,

by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

In the case of divorce, payment is expected from the parent/guardian who is with the patient. Parent/guardians are expected to work out payment arrangements with each other and not involve North Shore Dentistry for Children in any disputes.

We reserve the right to charge \$25.00 per half hour of scheduled time for appointments missed or not cancelled within 24 hours prior to the appointment. Charges will not exceed amount of treatment scheduled.

I have read the above conditions of treatment and agree to their content. I accept full responsibility for the payment of dental services rendered to my child/children _____ by North Shore Dentistry for Children.

DATE RELATIONSHIP TO PATIENT SIGNATURE OF PATIENT, PARENT OR GUARDIAN