Children's Dental Care
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(225) 924-2010
www.childrensdentalcarela.com

Child's name:_____Nickname:_____Sex: (M) (F)

Purpose of visit:_____Concerns:_____Birthdate:_____

Name & ages of siblings:_____

Child's Interests:_____Name of Pet(s):_____

Does your child have any special needs?_____Any phobias?_____

Child's learning: slow average accelerated Child's school:_____

Who may we thank for referring you to us?_____

HEALTH HISTORY

Child's Pediatrician_____Phone number: (_____)_____Last Physical:_____

Is your child under a physician's care now? Y N (if yes, reason) _____

Is your child taking any medications currently (including over the counter)? Y N (if yes, please list) _____

Is your child allergic to any medication? Y N (if yes, please list) _____

Any history of hospitalization or surgery: (if yes, when) _____

Does your child have an allergic reaction to: (if yes; please check all that apply)

_____Peanuts/Tree nuts	_____Soy	_____Latex/Rubber	_____Pollen/Dust/Environmental
_____Eggs	_____Metals	_____Animals	_____Berries
_____Milk	_____Wheat/Gluten	_____Dyes/Coloring	_____Anesthetics
_____Acrylic	_____Other:_____		

Has your child had a history or difficulty with any of the following? (please circle Y or N)

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Heart Murmur	Y N
Allergies to Medications	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down Syndrome	Y N	Rheumatic Fever/Heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visually Impaired	Y N

OTHER:_____

Parent's Initials:_____Date:_____

DENTAL HISTORY

Is this your child's first dental visit? Y N If no, previous dentist:_____Phone number: (_____)_____

Date of last visit:_____How was his/her experience?_____Were any x-rays taken? Y N

Childs attitude towards the dentist or dental care:_____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe:_____

Has your child done any of the following (past or present)?

Please circle: thumb/finger sucking pacifiers nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoride toothpaste? Y N

How often does your child brush his/her teeth?_____ With adult supervision? Y N How often does your child floss?_____

GENERAL INFORMATION

Father (first, last):_____SSN:_____DOB:_____Driver's License #_____

Mother (first, last):_____SSN:_____DOB:_____Driver's License #_____

Parent(s) are: Married Divorced Single Child lives with: both parents mother father other

Home Address:_____Home Phone: (_____)_____
Street City Zip

Father's Employer:_____Work# (_____)_____

Business Address:_____Cell# (_____)_____

Mother's Employer:_____Work# (_____)_____

Business Address:_____Cell# (_____)_____

E-mail Address:_____

Emergency Contact (other than yourself):_____Phone number (_____)_____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:_____Relationship:_____ Date:_____

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y N Person financially responsible for child's dental:_____

Primary Insurance Company:_____Group Number:_____

Secondary Insurance Company:_____Group Number:_____

FINANCIAL AGREEMENT

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any changes not covered by my insurance or by this authorization. I realize there is payment for additional services. I must provide accurate and complete insurance information in order for my dental claims to be processed promptly. I will be required to pay my portion the day of the dental treatment.
For patients without insurance: payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services.
A $35.00 CANCELLATION FEE WILL BE CHARGED TO ANY ACCOUNT THAT DOES NOT PROVIDE A 24 HOUR NOTICE FOR MISSED OR CANCELLED APPOINTMENTS.

SIGNATURE:_____Relationship:_____Date:_____