BRUSH SAMILES FLOSS DENTIST HEALTH DENTIST HEALTHY GUANS HYGIENIST



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 your child.

PATIENT INFORMATION

Address State Zip Phone Sex M F Age Birthdate School Grade Hobbies/Sports Whom may we thank for referring you? Home Phone Work Phone PRIMARY INSURANCE Person Responsible for Account Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Address (if different from child) Home Phone City State Zip Person Responsible Employed by Occupation Business Address Business Phone Insurance Company Phone Contract # Group # Subscriber # Name of other dependents under this plan Address (if different from child) Soc. Sec. # City State Zip Phone Subscriber # Name of other dependents under this plan Address (if different from child) Soc. Sec. # City State Zip Phone Subscriber Name Relation to Child Birthdate Address (if different from child) Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Phone Contract # Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Phone Contract # Group # Subscriber # Name of other dependents under this plan	Child's Name			Soc. Sec. #	
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Sex	Address	-	_		
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Whom may we thank for referring you? Notify in case of emergency	Sex D M D F Age Birthdate	e	School		
Person Responsible for Account Last Name First Name Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Address (if different from child) City State Zip Person Responsible Employed by Occupation Business Address Business Phone Insurance Company Contract # Name of other dependents under this plan Additional insurance? Person Responsible Employed by Relation to Child Birthdate Address (if different from child) Soc. Sec. # City State Zip Phone Address (if different from child) Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Contract # Subscriber Employed by Business Phone Insurance Company Phone Subscriber Employed by Business Phone Insurance Company Phone Subscriber #	Grade Hobbies,	/Sports			
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Person Responsible for Account Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Home Phone City State Zip Person Responsible Employed by Occupation Business Address Business Phone Insurance Company Phone Contract # Additional insurance? Is child covered by additional insurance? Additional insurance? Relation to Child Birthdate Soc. Sec. # City Soc. Sec. # City State Zip Phone Subscriber Finance Subscriber Employed by Business Phone Subscriber Employed by Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Phone Subscriber #	Notify in case of emergency		Home Phone	Work Phone	
Person Responsible for Account Last Name First Name Initial Relation to Child Birthdate Soc. Sec. # Home Phone City State Zip Person Responsible Employed by Occupation Business Address Business Phone Insurance Company Phone Contract # Additional insurance? Is child covered by additional insurance? Additional insurance? Relation to Child Birthdate Soc. Sec. # City Soc. Sec. # City State Zip Phone Subscriber Finance Subscriber Employed by Business Phone Subscriber Employed by Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Phone Subscriber #		Per	MARY INCURAN	CE	
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State	Relation to Child		Birthdate	Soc. Sec. #	
Person Responsible Employed by	Address (if different from child)			Home Phone	
Business Address	City		State	Zip	
Insurance Company Phone	Person Responsible Employed by			Occupation	
Contract # Group # Subscriber #	Business Address			Business Phone	
Additional insurance?	Insurance Company	-		Phone	
Additional insurance?	Contract #	_ Group #		Subscriber #	
Is child covered by additional insurance?	Name of other dependents under this plan	1			
Is child covered by additional insurance?		Anni	TIONAL INSURA	NCE	
Subscriber Name Relation to Child Birthdate Address (if different from child) Soc. Sec. # City State Zip Phone Subscriber Employed by Business Phone Insurance Company Phone Contract # Group # Subscriber #	le child covered by additional incurance?			102	
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Insurance Company Phone Contract # Group # Subscriber #	•		•		
Contract # Group # Subscriber #					

Please complete both sides.

DENTAL HISTORY What would you like us to do for your child today?_____ Former Dentist ______ Address _____ Phone _____ _____ Date of last x-rays ___ Date of last dental care ____ How often does your child brush? _____ __ Floss? ___ Does your child experience pain or discomfort in the jaw joint? \(\sim \text{Y} \subseteq \text{N}\) Has your child ever experienced a mouth or chin injury? ☐ Y ☐ N Does your child have speech problems? ___ Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? 🛛 Y 🚨 N Child's habits affecting the mouth or teeth: ☐ Thumb sucking ☐ Nail biting ☐ Other _____ Other information about your child's dental health or previous treatment _______ **MEDICAL HISTORY** Phone_ Child's Physician ____ Has your child had any serious illnesses or operations? 🛛 Y 🗀 N Date of last visit ____ If yes, describe _____ Is your child currently under physician care? 🔲 Y 👊 N If yes, describe____ If yes, give approximate dates_____ Has your child ever had a blood transfusion? ☐ Y ☐ N Check (✓) if your child has had any of the following: ☐ AIDS/HIV Positive ☐ Cough up blood ☐ Hemophilia/Abnormal bleed- ☐ Shortness of breath □ Diabetes ☐ Anemia ☐ Sinus problems ☐ Immunizations current ☐ Epilepsy ☐ Asthma ☐ Skin rash ☐ Kidney disease or ☐ Fainting ☐ Atopic (allergy prone) ☐ Spina Bifida malfunction □ Food allergies ☐ Blood disease ☐ Thyroid disease or ☐ Liver disease ☐ Headaches malfunction □ Cancer ☐ Material allergies (latex. ☐ Hearing Impairment ☐ Chicken Pox □ Tonsillitis wool, metal, chemicals) ☐ Heart problems ☐ Convulsions/Epilepsy ☐ Tuberculosis ☐ Respiratory disease Describe ____ □ Cough, persistent ☐ Rheumatic/Scarlet fever Other ____ List drug allergies, if any: List medications your child is taking, if any: AUTHORIZATION I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Signature _ Payment is due in full at time of treatment, unless prior arrangements have been approved. #80-783 SmartPractice