WELCOME

Tell Us About Your Child

Today's Date: _____ ☐ Male ☐ Female

Child's Home Phone #: (____)_____ Child's Age: _____

Child's Birthdate: ____/____/____ Social Security #:_____

Child's Name: _____
Last First MI

Nickname: _____

Hobbies: _____

School: _____ Grade: _____

Child's Home Address: _____
Street

_____
City State Zip

Who Is Accompanying the Child Today?

Name: _____ Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No

Is the child adopted? ☐ Yes ☐ No Is the child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____

Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street

_____
City State Zip

Parent's Information

Parent's Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single

Mother: ☐ Step Mother ☐ Guardian Birthdate: ___/___/___ Home Phone #: (____)_____ WorkPhone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #:_____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Father: ☐ Step Father ☐ Guardian Birthdate: ___/___/___ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #:_____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security #: _____

Billing Address: _____
Street City State Zip

Work Phone #: (___)_____ Home Phone #: (___)_____ Employer: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Work Phone #: (___)_____ Home Phone #: (___)_____ Best time to call: _____

Insurance Information

Primary

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

Secondary

Medical Coverage? ☐ Yes ☐ No Dental Coverage? ☐ Yes ☐ No Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

CONTINUED ON BACK

Medical History

Child's Physician: _____ Phone #: (____)_____ Date of last visit: _____

Address: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations Current?** ☐ Yes ☐ No

Please list all drugs that the child is currently taking: _____

Please list all drugs/materials that cause the child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No Explain: _____

Has the child had/experienced any of the following:

Y	N	Abnormal Bleeding	Y	N	Diabetes	Y	N	Low Blood Pressure
Y	N	AIDS / HIV+	Y	N	Epilepsy	Y	N	Lupus
Y	N	Anemia	Y	N	Handicaps / Disabilities	Y	N	Measles
Y	N	Allergies	Y	N	Hearing Impairment	Y	N	Mitral Valve Prolapse
Y	N	Any Hospital Stays / Operations	Y	N	Heart Murmur	Y	N	Mononucleosis
Y	N	Asthma	Y	N	Hemophilia	Y	N	Rheumatic Fever
Y	N	Blood Transfusion	Y	N	Hepatitis	Y	N	Scarlet Fever
Y	N	Cancer	Y	N	High Blood Pressure	Y	N	Sickle Cell Anemia
Y	N	Chicken Pox	Y	N	Hives	Y	N	Skin Rash
Y	N	Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Tonsillitis
Y	N	Convulsions	Y	N	Liver Problems	Y	N	Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

Dental History

Is the child currently in pain? ☐ Yes ☐ No **What is the primary reason for today's visit?** _____

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Has the child experience problems with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No Floss his / her teeth daily? ☐ Yes ☐ No

Previous / Present Dentist: _____ Date of last visit: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least about? _____

Does / did the child have any of the following habits?

Y	N	Lip Sucking / Biting	Y	N	Clenching / Grinding Teeth	Y	N	Tongue / Cheek Biting
Y	N	Nail Biting	Y	N	Used Pacifier	Y	N	Speech Problems
Y	N	Chewing on Objects	Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking	Y	N	Breast Fed

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian **Date**

I certify that my child is covered by _____ **Insurance Co. and I assign directly to Dr.** _____

By signing below, I give permission to Dr. Jarrell and her staff to provide treatment to the above named patient. I accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected for any co-payment and deductibles that my insurance does not cover for services rendered. A service charge of 1.5% per month (**annual percentage rate 18%**) will be added to all past due accounts. Any account over 30 days past due is subject to a minimum service charge of $10.00 per month. Should the services of an outside agency be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection. There will be an automatic surcharge of 30% of patient balance for any balance owed to account for collection fees. I authorize you to check my credit from any and all sources.

_____

Signature of parent or guardian **Date**

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been made.