Welcome to Family Dental Care

We Would like to welcome you and your child to our office. Our goal Is to make every child's visit comfortable and educational. We believe in preventative care and we strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell us about your child	**Primary Insurance:**
Today's Date:	Dental Coverage: Yes No
First Name: Middle Initial:	Insurance Company:
Last Name:	Insurance Company Address:
I prefer to be called:	City: State: Zip Code:
□Male □Female Birthdate : / /	Insurance Company Phone Number:
Age: Social Security Number:	Member ID: Group #:
Home Address:	Insured Subscriber Name: Relation: Birthdate: / /
City: State: Zip Code:	Insured's Social Security Number:
Home Phone:	Insured's Employer:
Parents Cell Phone:	Employer Address:
Work Phone:	City: State: Zip Code:
Email Address:	**Secondary Insurance:**
School: Grade:	Dental Coverage: Yes No
Previous Dentist:	Insurance Company:
Last dental cleaning and exam:	Insurance Company Address:
Who is accompany the child today?	City: State: Zip Code:
Name: Relation:	Insurance Company Phone Number:
Do you have legal custody of this child? Y N	Member ID: Group #:
Whom may we thank for referring you?	Insured Subscriber Name: Relation: Birthdate: / /
Other family members seen by us:	Insured's Social Security Number:
Mother's Information	Insured's Employer:
Name: Birthdate : / /	Employer Address:
Email Address:	City: State: Zip Code:
Main Contact Number:	Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Family Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. Signature:________________ Date: / /
Employer: Work Phone:	
Father's Information	
Name: Birthdate : / /	
Email Address:	
Main Contact Number:	
Employer: Work Phone:	

Medical History	Have you ever had any of the following diseases or medical problems?	
Why did you bring the child to the dentist today?		
Physician's Name:	Y N Abnormal Bleeding/Hemophilia	Y N Hospitalized for any reason
Phone: Date of Last visit: / /	Y N AIDS	Y N HIV
Has the child ever had a serious/difficult problem with previous dental work? Y N	Y N Alcohol/Drug Abuse	Y N High Blood Pressure
Please Explain:	Y N Anemia	Y N Colitis
Is the childs water fluoridated? Y N	Y N Arthritis	Y N Liver Disease
Has the child ever had any pain/tenderness in his/her jaw joint? Y N	Y N Kidney Problems	Y N Low Blood Pressure
Does the child brush his/her teeth daily? Y N	Y N Artificial Bones/Joints/Valves	Y N Mitral Valve Prolapse
Does the child floss daily? Y N	Y N Asthma	Y N Diabetes
Please Describe the child's physical health: Good Fair Poor	Y N Frequent Headaches	Y N Rheumatic/ Scarlet Fever
	Y N Cancer/Chemotherapy	Y N Radiation Treatment
Please List all the drugs the child is currently taking:	Y N Lupus	Y N Ulcers
	Y N Difficulty Breathing	Y N Emphysema
Are you allergic to any of the following?	Y N Sickle Cell Disease/Traits	Y N Heart Attack/ Surgery
Y N Aspirin / Y N Erythromycin / Y N Penicillin	Y N Fainting Spells	Y N Epilepsy
Y N Codeine / Y N Jewelry/Metals / Y N Sulfa	Y N Seizures	Y N Shingles
Y N Dental Anesthetics / Y N Latex / Y N Tetracycline	Y N Sinus Problems	Y N Glaucoma
Please list any other drugs/materials that your child is allergic to:	Y N Stroke	Y N Thyroid Problems
	Y N Hay Fever	Y N Heart Murmur
	Y N Tuberculosis (TB)	Y N Hepatitis
Neighbor or Relative not living with you	Y N Venereal Disease	
Name: Relation:	Please List any serious medical condition(s) that the child has ever had:	
Phone:		
Address:		
City: State: Zip Code:	**Does the child have any of the following habits?**	
Any additional info that we need to know:	Y N Lip sucking/Biting	Y N Nursing Bottle Habits
	Y N Nail Biting	Y N Thumb/Finger Sucking

I Understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

Name:________________________________Signature:________________________________ Date:____________

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