Welcome

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 you in maintaining your child's dental health.

Patient Information

Name____ SSN______________________
Last *First* *MI*

Address____

City____________________ State______ Zip__________ Home Phone____________________

Sex ☐ M ☐ F Age_________ Birthdate______________ Hobbies, Sports and Interests____________________

____

Whom may we thank for referring you?____

In case of Emergency:

Notify_____________________________________ Relationship to Patient____________________

Home Phone________________________________ Cell Phone______________________________

Work Phone________________________________ Email___________________________________

Primary Insurance

Person Responsible for Account____
Last *First* *MI*

Relationship to Patient__________________________ Birthdate____________ SSN__________________

Address (If different from patient)____

City____________________ State______ Zip__________ Home Phone____________________

Cell Phone__________________________ Email_____________________________________

Employer___________________________________ Occupation________________________

Business Address____________________________ Business Phone______________________

Business Email____

Insurance Company_________________________________ Phone_____________________

Contract #____________________ Group #________________ Subscriber #____________________

Name(s) of other dependent(s) under this plan_______________________________________

Additional Insurance

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name____
Last *First* *MI*

Relationship to Patient__________________________ Birthdate____________ SSN__________________

Address (If different from patient)____

City____________________ State______ Zip__________ Home Phone____________________

Cell Phone__________________________ Email_____________________________________

Employer___________________________________ Occupation________________________

Business Address____________________________ Business Phone______________________

Business Email____

Insurance Company_________________________________ Phone_____________________

Contract #____________________ Group #________________ Subscriber #____________________

Name(s) of other dependent(s) under this plan_______________________________________

Please Complete All Pages of Form

Scheidies Cosmetic and Family Dentistry

Dental History

Primary Reason for Visit______________________________________ Is your child in dental discomfort today? ☐ Yes ☐ No

Former Dentist____ Address____

Phone____ Email____

Date of last dental care_____________________________________ Date of last x-rays____

Has your child had any previous unfavorable dental experience? ☐ Y ☐ N If yes, explain_____________________________________

____

Check (✓) if your child has/has had any of the following:

☐ Bad breath

☐ Bleeding gums.
How long?_______________

☐ Clenching or grinding of teeth

☐ Complications from extractions

☐ Food Impaction

☐ Frequent blisters on lips or mouth

☐ Mouth breathing

☐ Oral habits (thumbsucking, fingernail biting, cheek biting, etc)

☐ Orthodontic treatment

☐ Pain around ear

☐ Swelling or lumps in mouth

☐ Teeth sensitive to *(circle)*: cold, heat, sweets, pressure

Check (✓) if your child uses any of the following:

☐ Between meal snacks

☐ Dental floss

☐ Disclosing tables or solution

☐ Flouride supplements

☐ Toothbrush

☐ Topical fluoride treatment

☐ Well balanced diet

How often does your child brush?_______________ Texture of toothbrush______________ How often does your child floss_____________

Medical History

Physician's Name____ Phone____________________________________

Date of last visit____________________________________ Child's Age_______________

Check (✓) if your child has/has had any of the following:

☐ Allergy to **latex**

☐ Allergies to anesthetics

☐ Any heart ailments

☐ Anemia

☐ Asthma

☐ Diabetes

☐ Excessive bleeding from cut or extraction

☐ Extreme nervousness or apprehension

☐ Eye disorders

☐ Hay fever or allergies in general

☐ Immune system disorders (AIDS, HIV, ARC)

☐ Kidney problems

☐ Liver problems or hepatitis

☐ Malignancies or Leukemia

☐ Physical or mental handicap

☐ Psychiatric care/emotional problems

☐ Radiation treatments

☐ Rheumatic fever

☐ Sinus problems

☐ Thyroid disorders

☐ Tonsillitis

☐ Ulcer(s) or colitis

Describe any current medical treatment or ailments (including all drugs taken) even though not listed above___________________________

____

Does your child have any drug allergies? If yes, list all____

Please Complete All Pages of Form

Scheidies Cosmetic and Family Dentistry

Appointments: A minimum charge will be made for missed or cancelled appointments without prior notification of 24 hours. Once an appointment has been made, please remember this time has been reserved for the patient.

Insurance: We will assist in filing a claim with your insurance company, however all fees are the sole responsibility of the patient/responsible party.

Authorization

I have reviewed the information on this document, 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 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 of Parent/Guardian____ Date_____________

Payment is due in full at the time of treatment, unless prior arrangements have been approved.

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