CHILD PATIENT INFORMATION

Child's Name___________________________ Sex M_____F_____ Birthdate____/_____/_____

Responsible parent's name____ Birthdate____/_____/_____

Street address____City,State, Zip__________________________

Relationship to child______________Home phone______________Cell phone________________

Occupation_______________Employer_________________Work phone______________

Other parent's name__________________________________Birthdate___/_____/_____

Street address (if different)__________________________________City,State,Zip__________________________

Relationship to child______________Home phone______________Cell phone________________

Occupation_______________Employer_________________Work phone______________

Which parent is responsible for the account?__________________

Who should we contact for making and confirming appointments?____________Preferred phone___________

Name of emergency contact not in your household____

Relationship_______________ Phone____________________

DENTAL INSURANCE INFORMATION

Subscriber name____________________________________ Birthdate____/_____/_____

Relationship to patient_______________________________ Subscriber ID#___________________

Insurance company__________________________________ Group#_________________________

Secondary insurance company________________________ Subscriber name_________________

Relationship to patient_______________________________ Subscriber ID#___________________

Group #__________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I assign directly to Maharry Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not covered or paid by insurance. I hereby authorize Maharry Family Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ _____________

Signature of parent or guardian Date

CHILD'S DENTAL HISTORY

Reason for today's visit_______________
____
Former dentist_____________________
City/State__________________________
Date of last dental x-rays_____________
Please check any of the following you are experiencing:
_______Bad breath
_______Loose teeth or broken fillings
_______Jaw pain or tiredness
_______Bleeding gums
_______Clicking or popping jaw
_______Grinding teeth
_______Gums swollen / tender
_______Orthodontic treatment
_______Periodontic treatment
_______Sensitivity to pressure/chewing
_______Sensitivity to cold
_______Sensitivity to sweets
_______Tobacco use
Is this the child's first dental visit?______
Is the child worried or apprehensive?___

Please list all of the medications you are prescribed:_________________________
____
____
____
____
____
____

CHILD'S MEDICAL HISTORY

Date of last medical examination___________________________________
Primary care physician_____________________________________
Physician's phone____

Do you have or have you ever had any of the following?

Yes____No____Artificial heart valve
Yes____No____History of bacterial endocarditis
Yes____No____Congenital heart disease
Yes____No____Surgical repair of congenital heart defect, date_________
Yes____No____Organ transplant,details__________________________
Yes____No____Prosthetic joint replacement, date & joint type_________
____
Yes____No____Artificial implant or graft of any kind not listed_________
____
Yes____No____Immunosuppressive condition (circle all that apply) steroid therapy, radiation or cancer therapy, lupus, rheumatoid arthritis, organ transplant, other__________
Yes____No____Physician requests antibiotic coverage for dental treatment, reason_________________________________
Yes____No____AIDS, HIV
Yes____No____Epilepsy, seizure disorder
Yes____No____Hepatitis
Yes____No____Coumadin(warfarin) or other blood thinner therapy
Yes____No____Drug / alcohol abuse
Yes____No____Abnormal blood pressure: High or Low
Yes____No____Difficulty breathing, details_________________________
Yes____No____Diabetes
Please list any other medical conditions you have that may affect your dental treatment:____

Drug Allergies:
_______Penicillin, amoxicillin antibiotics
_______Local anesthetic
_______Latex or rubber
_______Codeine, hydrocodone
_______Cephalosporin antibiotics
_______Others, list____

I acknowledge that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. Permission is hereby granted Maharry Family Dentistry to perform necessary dental treatment for my child:

____ _______________

Signature Date