WELCOME TO OUR PRACTICE

We are pleased to welcome you and your child to our practice. Plesae take a few mintues to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to helping you care for your childs dental health.

Patient Information

Insurance

Dental History

Patient Information

Date_____ Birthdate _____

Name of Child _____ Sex M☐ F☐ Age_____

Nickname _____ Cell Phone (___)_____

Hobbies _____

Home Address _____

Mailing Address _____

School Name _____ School Phone _____

Person financially responsible _____ Home Phone (___)_____

Who may we thank for referring you? _____

Insurance

Primary Insurance Carrier _____

Primary Carrier Phone (if different from above) _____

Primary Carrier Address (if different from above) _____

Name of Insurance _____ Telephone _____

Address _____

Group # _____ Subscriber ID # _____

Employer _____Birthdate _____

Soc. Sec. # _____E-Mail _____

Dental History

Date of last visit to a dentist _____For what service _____

Has child complained about dental problems?	Yes	No
Does child brush teeth daily? ……	Yes	No
Does child use floss everyday? ……	Yes	No
Does child use fluoride? ……..	Yes	No
Any injuries to mouth, teeth, head? ……..	Yes	No
Any unhappy dental experiences? …….	Yes	No

Jet Set SMILES
PEDIATRIC DENTISTRY

Medical History

Medical History

Child's Physician _____ Telephone _____
Date of last physical exam _____
Is child under care of physician now? Yes No
Receiving any medication? ……. Yes No
Ever been hospitalized? …….. Yes No
Ever had surgery? ……. Yes No
Any medications? …… Yes No
Please list
_____
_____
Allergies
_____
_____

Emergency Contact

Emergency Contact
In the event of an emergency, whom should we contact?
Name _____ Relationship_____ Phone _____
Name_____ Relationship _____ Phone _____

Authorization

Authorization
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

Consent
I am the parent, guardian, or personal representative of _____
Please Print Name of Child
and there are no court orders now in effect that prohibit me from signing consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor.

I authorize doctor to disclose healthcare information to above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Parent, Guardian or Person Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relationship to patient

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