

Personal Information

Date: _____

Child's Name _____ Nickname (if any) _____ Sex _____

Age _____ Birth Date _____ Place of birth _____

Attends what school _____

Name and age of brothers _____

Name and age of sisters _____

Is child adopted (Please circle) Yes No If yes, does child know Yes No

Parent's Marital Status: (Please circle) Single Married Widowed Divorced Separated

Whom may we thank for referring you _____

Father or Parenting Adult Relationship to Child _____

Name: _____

Address: _____

City: _____ State _____ Zip _____ Home Phone: _____

Social Security # _____ Driver's License # _____ State _____

Employer: Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Occupation: _____

Mother or Parenting Adult Relationship to Child _____

Name: _____

Address: _____

City: _____ State _____ Zip _____ Home Phone: _____

Social Security # _____ Driver's License # _____ State _____

Employer: Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Occupation: _____

Parent with whom child lives _____

Friend or Relative, not at same residence (To contact in case of emergency)

Name: _____ Phone: _____

Address _____

City: _____ State _____ Zip _____

Name of dental insurance, if any _____

I, the undersigned, assign directly to Dr. Poiset all dental benefits, if any, otherwise payable to me for services rendered to my child. I understand that I am financially responsible for all charges whether or not paid by insurance, and hereby authorize the doctor to release and/or obtain dental records as needed for my treatment or to assist in obtaining insurance reimbursement on my behalf. I understand that a finance charge of 0.83% per month will be added to all balances over 90 days. If legal action and/or assignment to an attorney or collection agency should become necessary to collect my account, I agree to pay all costs of collection including court costs, collection agency commissions and costs, and reasonable attorney fees.

Signature of Parent or Guardian

Date

Medical History

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No		Yes	No
Is child under care of physician now _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child have a heart murmur or any heart problems _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Is child taking any medications or drugs _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever been hospitalized _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any serious medical or physical problems _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever had surgery _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____ _____ _____ _____		
Does child have asthma or lung problems _____ _____	<input type="checkbox"/>	<input type="checkbox"/>			
Is there any allergy to penicillin or other drugs _____ _____	<input type="checkbox"/>	<input type="checkbox"/>			

Has child any history of or difficulty with any of the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chronic Sinus Infections | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Allergies to Foods | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergic to Latex | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV+/ AIDS | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Breaths only through mouth | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hyperactive/ ADD | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Handicaps or Disabilities | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Vision Impairment |

Dental History

	Yes	No		Yes	No
Has child been to dentist before _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child brush teeth daily _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Date of last visit _____					
Does child have any dental problems at present _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist with tooth brushing _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental or medical experiences _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Does child suck a thumb - finger - pacifier _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth or teeth _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
Does child grind teeth or clench jaws _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
			Tablets - drops - water		
Does child currently use a bottle _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's attitude toward dentistry _____ _____		
Does child currently nurse _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Reason for today's visit _____ _____ _____		
Name of parents' Dentist _____ _____					

Consent to Treat Minor

I understand that the information 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 the dental staff of any changes in my child's health status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____

Office Use Only

Examining Doctor's Initials _____
Date _____