WEST MAIN
FAMILY DENTISTRY

Patient Information and Health History

We would like to get to know you better.

Child's Name:
First_____ M.I._____ Last _____
Date of Birth _____ **Phone** (____) _____
Address: _____ City _____
State _____ Zip Code _____ **Soc. Sec. #**_____

Mother's Name_____
Address _____
Phone (____) _____
Soc Sec# _____Date of birth_____
Employer _____
Employer's Address_____
Work (____) _____ Ext. _____

Father's Name_____
Address _____
Phone (____) _____
Soc Sec# _____Date of birth_____
Employer _____
Employer's Address_____
Work (____) _____ Ext. _____

Person responsible for payment _____ Referred to us by _____
Emergency contact Name _____ Phone (____) _____
Address _____ Relationship _____

DENTAL INSURANCE INFORMATION

Primary Subscriber's Name_____
Subscriber's Birthday _____
Insurance Carrier_____
Insurance ID # _____
Group # _____
Subscriber's Soc Sec #_____
Subscriber's Employer _____

Secondary Subscriber's Name_____
Subscriber's Birthday _____
Insurance Carrier _____
Insurance ID # _____
Group # _____
Subscriber's Soc Sec #_____
Subscriber's Employer _____

Medical Information: Child's Primary Care Doctor _____
Phone (___) _____ City _____ Date of last physical exam _____

Indicate which of the following your child has had or has at present. Circle "yes" or "no" to each item.

Allergies to medications. . . . . Yes No	Previous bacterial endocarditis Yes No	Asthma . . . . . Yes No
Allergies to anesthetics . . . .. . Yes No	Artificial heart valve . . . . . Yes No	Rheumatic fever . . .. Yes No
Diabetes. . . . . Yes No	Mitral valve prolapse. . . . . Yes No	Respiratory disease . . . . . Yes No
Epilepsy . . . . . Yes No	Heart murmur . . . . . Yes No	Healing complications. . . . . Yes No
Orthopedic joint replacement. Yes No	Any heart ailments . . . . . Yes No	Chicken Pox . . . . . Yes No
Tuberculosis . . . . . Yes No	Hepatitis . . . . . Yes No	HIV positive . . . . . .Yes No

Has your child ever been hospitalized? ……Yes No
If so, please specify _____
Describe any current medical treatment, conditions, medications taken, and allergies to medications, even if not listed above_____
_____
_____

*Please turn to second page**

DENTAL HISTORY

<u>Indicate which of the following your child has had or has at present</u>. *Circle "yes" or "no" to each item.*

Tooth sensitive to cold ……Yes No
Tooth sensitive to heat ……..Yes No
Tooth sensitive to sweets ……..Yes No
Tooth sensitive to pressure…….Yes No
Clenching or grinding…… Yes No
Swelling or lumps in mouth……..Yes No
Bleeding gums…… Yes No
Unfavorable dental experience…….. Yes No
Traumatic injury (mouth or teeth)…… Yes No
Frequent blisters (lips or mouth)…….. Yes No

Complications from extractions……. Yes No
Oral habits (thumbsucking, etc) ……Yes No
Bad breath……Yes No
Unusual speech habits …… Yes No
Orthodontic treatment …….. Yes No
Electric toothbrush ……Yes No
Fluoride supplements …….. Yes No
Fluoride rinse …….. Yes No
Dental floss……Yes No
Soft bristle toothbrush …….. Yes No

Has your child complained about dental problems? …….. Yes No
Does your child brush and floss daily? ……...Yes No
Do you assist child with tooth brushing?.....Yes No
Child's attitude to dentistry _____

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF EACH VISIT.

I hereby assign all Dental/Medical benefits, to which I am entitled:

This assignment will remain in effect during the course of treatment. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges to secure the payment.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payments. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. For your convenience, we accept MasterCard, Visa, Discover, and American Express.

If this account is assigned to a collection agency for collection and/or suit, I / We will be responsible for costs of collection and / or reasonable attorney's fees.

_____

Signature of Parent / Guardian **Date**