Children's Dentistry of Morristown

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Childs Name _____ ( ) Male ( ) Female

Date of Birth _____ Child's Age _____ Nick name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail _____

Have your brothers and sisters been seen in this office? _____

If yes, Name & Ages of Brothers & Sisters _____

Who shall we thank for referring you to our office? _____

Child's Physician/Pediatrician _____

Address & Phone _____

Date of last Medical Exam _____ Are all Immunizations up to date? _____

Is your child taking any medications? _____

Has your child ever had any unusual reactions to any medications? _____

MEDICAL HISTORY

__Allergies _____

__ADD/ADHD __Convulsions __Immune Disorders __Psychiatric Evaluations ___Seizures ___Pregnancy
__Diabetes ___HIV ____Past Hospitalizations ___Autism ___PDD___Heart Problems ___Brain Injury
__ Glandular Problems __ Kidney Problems__ Rheumatic Fever __Bleeding Disorders __Cancer __Asthma
__ Liver Disease ___Respiratory Disorder ___Heart Murmur Other _____

NOTE: It is VERY important for the health of your child that medical clearance for heart murmur/problems be documented

DENTAL HISTORY INFORMATION

What is the chief reason for this visit? _____
Has your child received dental care before? _____ If yes, explain _____
Has your child experienced any major injury to the jaw or face? _____ If yes, explain _____
Does your child have any of the following? (Please circle all that apply)
Thumb sucking Finger sucking Pacifier Mouth Breathing Nail Biting Lip Biting
Was your child breast/bottle fed? Breast Bottle To what age? _____
Does/did your child fall asleep with a bottle or while nursing? _____
How often does your child brush? _____
Has your child ever had a fluoride treatment? _____
Is your child taking a fluoride supplement? If so, which one? _____

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FINANCIAL INFORMATION

MOTHER'S INFORMATION

Name _____

Address _____

City/St/Zip _____

Home Phone _____

DOB _____

SS# _____

Employer _____

Address _____

City/St/Zip _____

Work Phone _____

Dental Ins _____

Group# _____

Primary _____ Secondary _____

FATHER'S INFORMATION

Name _____

Address _____

City/St/Zip _____

Home Phone _____

DOB _____

SS# _____

Employer _____

Address _____

City/St/Zip _____

Work Phone _____

Dental Ins _____

Group# _____

Primary _____ Secondary _____

CONSENT FOR TREATMENT

I certify that the above information is true and correct. I also, give consent for my child to be examined and receive dental treatment as the dentist deems fit after consultation with the parent.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services.

A service charge of 1 ½% per month (18%per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied.

A $75 fee will be incurred for missed appointments without 24 hour notice.

I understand that payment is expected for services at the time it is rendered unless previous arrangements have been made or within five (5) days of billing if credit shall be extended.

I grant permission to your assignee to telephone me at home or work to discuss matters related to this form.

Signature _____ Date _____

Relationship to Patient _____

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