

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Nickname \_\_\_\_\_ Child S/S \_\_\_\_\_

Guarantor 1 - Relationship to Patient \_\_\_\_\_  
Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
S/S # \_\_\_\_\_ Birthdate \_\_\_\_\_ D.L. # \_\_\_\_\_  
Occupation \_\_\_\_\_ Company Name \_\_\_\_\_

Guarantor 2 - Relationship to Patient \_\_\_\_\_  
Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
S/S # \_\_\_\_\_ Birthdate \_\_\_\_\_ D.L. # \_\_\_\_\_  
Occupation \_\_\_\_\_ Company Name \_\_\_\_\_

Who does child reside with \_\_\_\_\_ Relationship \_\_\_\_\_  
**Telephone # to verify appointments** \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
Mailings (post cards/reminder cards) are mailed to \_\_\_\_\_ Email: \_\_\_\_\_

Please tell us how you heard about our office \_\_\_\_\_  
What is the Child's Favorite Toy \_\_\_\_\_ Favorite Hobby \_\_\_\_\_  
Number of Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Favorite Fictional Character \_\_\_\_\_

**Do you have Dental Insurance:**  Yes  No

Insured's Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

## MEDICAL HISTORY

Child's Medical Doctor: \_\_\_\_\_ Has this child ever had any of the following (Circle those that apply)

AIDS or HIV Infection	Cancer	Other Immunosuppressive Disorders
Allergies to Anesthetics	Diabetes	Pregnant
Allergies to Medicines or Drugs	Epilepsy, Seizures	Problems with Blood Pressure
_____	<b>Heart Murmur</b>	Radiation Treatment
Other Allergies _____	<b>Heart Problems</b>	<b>Respiratory Disease</b>
Arthritis	Hemophilia, Bleeding Problems	<b>Rheumatic Fever</b>
<b>Artificial Joints or Heart Valves</b>	Hepatitis, Jaundice or Liver Disease	Sickle Cell Anemia
<b>Asthma</b>	MRSA	Swollen Neck Glands
Attention Deficit Disorder	Nervous Problems	Thyroid Problems
Blood Disease	Organ Transplant	

\_\_\_\_\_ initial **This child has not had any of the above listed conditions.**

This child has (has had) the following **condition not listed above.** \_\_\_\_\_

**Hospitalizations** (when and for treatment of what) \_\_\_\_\_

**Medications** being taken \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

Medical Alert

**DENTAL HISTORY**

Parents' Dentist _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is this your child's first visit to the dentist	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has child complained of any dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your child brush daily	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist with brushing	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth-head-teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits (thumb/finger sucking, nail biting, mouth breathing, pacifier, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything you would like to change about your child's smile? _____			How do you think your child will react to dental treatment _____		

I consent to and authorize dental treatment for my child by the Doctors and staff at BSWH, as prescribed by the doctors. Treatment may include, but will not be limited to cleanings, fluoride treatments, x-rays, injection of medications, Nitrous Oxide (Happy Air), fillings, tooth removal, space maintenance and crowns (caps). I consent to the taking of photographs and to the use of same in scientific papers and demonstrations. I consent to dental assisting students observing and participating in the care of my child under the direct supervision of the Doctors and staff of BSWH. I have been informed that, should I not understand any explanation(s) given to me, or have questions about treatment, I am encouraged to seek clarification from the Doctors. I am aware that the Doctors will make themselves available to me to answer any questions I may have at a mutually convenient time, whether that time is before, during or after office hours. I consent to bill Dental Insurances for services rendered. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**NOTES:**

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