

Patient ID# _____

Today's Date _____



Hillsborough Family Dentistry & Village Point Dentistry

Preventative & Emergency Dental Care Specialists

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

- Mother
- Stepmother Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

Occupation _____

DL # _____

Email _____

(Not required - complete only if we may contact you for appointment confirmations or general office information.)

- Father
- Stepfather Guardian

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

SS#/SIN _____

Employer _____

Occupation _____

DL # _____

Email _____

(Not required - complete only if we may contact you for appointment confirmations or general office information.)

Parent's Marital Status

- Single Divorced
- Married Widowed
- Separated

Your Child

Child's Name _____

Nickname _____ Sex _____

Birth Date _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State _____ Zip _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address 01 _____

Address 02 _____

SS#/SIN _____

DL # _____

Email _____

(Not required - complete only if we may contact you for appointment confirmations or general office information.)

Who is responsible for making appointments?

Name _____

Home Phone _____

Work Phone _____ Ext. _____

Cell Phone _____

Best time to call (Time) _____ (Days) _____

(Continued)

PRIMARY DENTAL INSURANCE

Insured's Name _____ Relationship _____
 Birth Date _____ SS#/SIN _____
 Employer _____ Date Employed _____
 Occupation _____
 Insurance Company _____ Group# _____ Emp.# _____
 Deductible _____ Amount Already Used _____ Max. Annual Benefit _____
 Orthodontic Coverage Yes No

ADDITIONAL INSURANCE

Insured's Name _____ Relationship _____
 Birth Date _____ SS#/SIN _____
 Employer _____ Date Employed _____
 Occupation _____
 Insurance Company _____ Group# _____ Emp.# _____
 Deductible _____ Amount Already Used _____ Max. Annual Benefit _____
 Orthodontic Coverage Yes No

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

HEALTH HISTORY (PLEASE CIRCLE ALL ANSWERS)

Has your child had difficulty with previous visits? Yes No

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? Yes No

Has your child ever taken Fen-Phen/Redux? Yes No

Has your child ever had any of the following:

Asthma	Yes	No	Rheumatic Fever	Yes	No
Cancer.....	Yes	No	Congenital Heart Defect	Yes	No
Hepatitis	Yes	No	Handicaps / Disabilities	Yes	No
HIV/AIDS	Yes	No	Convulsions / Epilepsy	Yes	No
Hemophilia	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Abnormal Bleeding	Yes	No
Allergies	Yes	No	Heart Murmur	Yes	No

CHILD'S HABBITS (PLEASE CIRCLE ALL ANSWERS)

How often does your child brush? _____

How often does your child floss? _____

Is your child's water flouridated? Yes No

Does your child take fluoride supplements?..... Yes No

(Continued)

CHILD'S HABITS (PLEASE CIRCLE ALL ANSWERS)

Does your child:

Suck thumb / finger	Yes	No	Chew hard objects (pencils, etc.)	Yes	No
Suck / Bite lips	Yes	No	Grind Teeth	Yes	No
Bite / Chew nails	Yes	No	Clench jaws	Yes	No

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor

Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

DENTIST'S REVIEW

Date _____

Signed Dr. _____

HEALTH HISTORY UPDATE

Date _____

Comments _____

Signature _____

Date _____ Comments _____

Signature _____