Ochoco Family Dental

Patient ID#_____ Today's Date_____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name_____

Nickname_____ Sex_____

Birthdate_____ Age_____

Soc. Sec. #_____

School_____ Grade_____

Child's Home Address_____

City, State, Zip_____

Phone_____

Responsible Party

Name_____

Relationship_____

Address_____

City, State, Zip_____

Soc. Sec. #_____

DL#_____

Who is responsible for making appointments?

Name_____

Home Phone_____

Work Phone_____ Ext._____

Best time to call_____

Time_____ Days_____

_____

Mother ☐Stepmother ☐Guardian

Name_____

Home Phone_____

Work Phone_____ Ext._____

Employer_____

Occupation_____

Soc. Sec. #_____

DL #_____

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Father ☐Stepfather ☐Guardian

Name_____

Home Phone_____

Work Phone_____ Ext._____

Employer_____

Occupation_____

Soc. Sec. #_____

DL #_____

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Primary Insurance

Insured's Name_____

Relationship_____

Birthdate_____ Soc. Sec. #_____

Employer_____ Date Employed_____

Occupation_____

Insurance Company_____

Group #_____ Employee #_____

Ins. Co. address_____

City, State, Zip_____

Deductible_____ Copay_____

Amount already used_____

Max. annual benefit_____

Additional Insurance

Insured's Name_____

Relationship_____

Birthdate_____ Soc. Sec. #_____

Employer_____ Date Employed_____

Occupation_____

Insurance Company_____

Group #_____ Employee #_____

Ins. Co. address_____

City, State, Zip_____

Deductible_____ Copay_____

Amount already used_____

Max. annual benefit_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐Cash ☐Personal Check ☐Credit Card ☐Visa ☐MC ☐I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID# _____

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.

How often does your child brush? _____ How often does your child floss? _____

☐ Yes ☐ No Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements?

Does your child:

☐ Yes ☐ No Suck thumb/finger ☐ Yes ☐ No Chew hard objects (pencils, etc.)

☐ Yes ☐ No Suck/Bite lip ☐ Yes ☐ No Grind teeth

☐ Yes ☐ No Bite/Chew nails? ☐ Yes ☐ No Clench jaws

Previous dentist? _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____

_____

_____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

☐ Yes ☐ No Asthma ☐ Yes ☐ No Handicaps/Disabilities

☐ Yes ☐ No Cancer ☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Hepatitis ☐ Yes ☐ No Diabetes

☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No Rheumatic Fever

☐ Yes ☐ No Hemophilia ☐ Yes ☐ No Congenital Heart Defect

☐ Yes ☐ No Abnormal Bleeding ☐ Yes ☐ No Heart Murmur

☐ Yes ☐ No Stomach, liver or kidney problems ☐ Yes ☐ No Convulsions/Epilepsy

Please explain any medical problems that your child has: _____

_____

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 also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my 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

Dentist Review:

_____

Signature of Dentist Date