Welcome!

We are glad you have chosen to allow us the privilege of serving your child's dental health needs.
Please provide the following information before we see your child. Thank you.

Your Child

Child's Full Name: _____
Nickname: _____ Gender: _____
Birthdate: _____ Age: _____
Social Security Number: _____
School: _____ Grade: _____
Child's Home Address:: _____
_____
Phone Number: _____
Is child adopted or under foster care?: _____
Child's Hobbies, Favorite Activities: _____
_____
Any Pets?: (What, names) _____

☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

Name: _____
Soc. Sec. Number: _____ Birthdate: _____
Home Address: _____
_____
Home Phone #: _____ Work Phone #: _____
Occupation: _____
Employer: _____
Employer's Address: _____
Hobbies/Interests: _____

☐ **Father** ☐ **Stepfather** ☐ **Guardian**

Name: _____
Soc. Sec. Number: _____ Birthdate: _____
Home Address: _____
_____
Home Phone #: _____ Work Phone #: _____
Occupation: _____
Employer: _____
Employer's Address: _____
Hobbies/Interests: _____

Parents' Marital Status:
☐ Married ☐ Single ☐ Divorced
☐ Separated ☐ Widowed ☐ _____

Brothers, Sisters: (Names, ages) _____
_____

General Information

Referred by: Dr. _____
☐ Yellow Pages ☐ Drove by / saw sign
☐ Friend / another patient: (who?) _____
☐ Blue Pages ☐ Received Welcome Card

Reason for visit:
☐ Check up ☐ Consultation
☐ Problem: _____

Who is primarily responsible for financial arrangements?
_____
Address/phone # (if different than already listed:
_____
Other than a parent, whom should we contact in case of an emergency? (Name/phone #) _____
_____

Primary Dental Insurance:

Insured's Name: _____
Insured's Phone #: _____ Work #: _____
Address: _____
Birthdate: _____ Relationship to Child: _____
Employer: _____
Insurance Company: _____
Group #: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
_____
ID#: _____ Soc. Sec. #: _____

Secondary Dental Insurance:

Insured's Name: _____
Insured's Phone #: _____ Work #: _____
Address: _____
Birthdate: _____ Relationship to Child: _____
Employer: _____
Insurance Company: _____
Group #: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
_____
ID#: _____ Soc. Sec. #: _____

Is child covered by any other policy? Yes / No

>>> Please continue on the other side of this form >>>

Children are a heritage from the Lord. - Psalm 127:3

Patient Health History

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

General Information regarding your child:

Does your child currently suck ☐ *a thumb* ☐ *finger(s)* ☐ *a pacifier* ☐ *none.*
Did he/she suck one of the above in the past? *How long?*
Does your child have any other habits, such as biting nails?
As an infant, did your child ☐ *drink from a bottle or* ☐ *breast-feed?* *Age discontinued:* _____
Does your child take vitamins, fluoride, iron, or other nutritional supplements? ☐ Yes ☐ No *What?* _____
Is your child doing well in school: ☐ Yes ☐ No *Does your child get along well with other children?* ☐ Yes ☐ No
Has your child had previous "bad" experiences at the doctor, dentist, or other health care facility?
☐ Yes ☐ No *If yes, please explain:* _____
Name of the child's Pediatrician / Physician: _____ *City:* _____
Date of last dental visit: _____ *Dr's. Name:* _____ *City:* _____
Do you think your child will be a cooperative dental patient? ☐ Yes ☐ No *Why?*

Please check whether or not your child now has or <u>has</u> <u>ever</u> had any of the following:

☐ Yes	☐ No	*Hearing Problems*	☐ Yes	☐ No	*Eye Problems*
☐ Yes	☐ No	*Speech Problems*	☐ Yes	☐ No	*Feeding / Eating Problems*
☐ Yes	☐ No	*Immunology / Endocrine Problems*	☐ Yes	☐ No	*Liver , Stomach, or GI Problems*
☐ Yes	☐ No	*Eczema / Skin Problems*	☐ Yes	☐ No	*Kidney / Bladder Problems*
☐ Yes	☐ No	*Allergies / Sinus Problems*	☐ Yes	☐ No	*High Cholesterol*
☐ Yes	☐ No	*Asthma / Wheezing*	☐ Yes	☐ No	*Diabetes*
☐ Yes	☐ No	*Other Respiratory Problems*	☐ Yes	☐ No	*Blood transfusions*
☐ Yes	☐ No	*Hepatitis*	☐ Yes	☐ No	*Congenital Birth Defect(s)*
☐ Yes	☐ No	*HIV / AIDS*	☐ Yes	☐ No	*Heart Murmur, Rheumatic Fever*
☐ Yes	☐ No	*Tuberculosis, other major infections*	☐ Yes	☐ No	*Other Heart Problems*
☐ Yes	☐ No	*Hemophilia, other Blood Disorders*	☐ Yes	☐ No	*Emotional Problems, Disorders or any Suicide Attempts*
☐ Yes	☐ No	*Seizures / Epilepsy or Head Concussion*			
☐ Yes	☐ No	*High Blood Pressure*	☐ Yes	☐ No	*Sexually Transmitted Disease*
☐ Yes	☐ No	*Cancer or any Tumors*	☐ Yes	☐ No	*Physical or Mental Delays, Handicaps, or Disabilities*
☐ Yes	☐ No	*Pregnancy*			

Please explain any yes answers: _____

_____

_____

Allergies: Does your child have any known allergies, sensitivities or reactions to any drugs, foods, or chemicals?
If yes, please explain: _____

_____

Medications: Please list all medications your child currently takes.

<u>Drug</u>	<u>Strength</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations or Serious Illnesses: Please list any hospitalizations, serious, and/or unusual illnesses which your child has experienced.

<u>Date(s)</u>	<u>Reason/Problem</u>	<u>Hospital/Physician</u>	<u>City, State</u>
_____	_____	_____	_____
_____	_____	_____	_____

Anything else we should know about?

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 doctor's office of any changes in my child's medical status. I authorize Dr. Creath and his staff to perform the necessary services my child may need.

_____ _____
Signature of parent / guardian (or patient, if appropriate) Today's Date

Doctor's Signature: _____ Review Date: _____

Authorization to Bring Patient, Consent to Treatment, Be Informed of Patient's Personal Information:

Please note that at least one of the child's legal guardians must be physically present during the patient's initial elective visit to our office. Exception to this policy requires prior authorization from our office.

Besides the parents / legal guardians listed on the front of this form, we need to know who else may have your permission to: 1) bring the child to a future appointment, 2) consent to treatment or changes in treatment, 3) be informed of the status of the patient's financial account, and 4) be informed regarding the patient's personal health information. For example, we cannot tell another person whether the patient has a cavity or what the balance is on the patient's account without prior written authorization from the patient's legal guardians.

Carefully consider all those people who may be involved in the patient's future visits to our office. For instance, treatment which was planned may change once procedures have begun that day because of unexpected findings or complications. Can another person authorize a necessary change to the treatment or must we contact you during the middle of the procedure? *Please note that if someone other than the individuals listed below bring the child to our office, we will be unable to see the child without your written permission.* Please understand this policy is for you and your child's protection and to facilitate good communication between our office and you.

Name	Relationship to Child*	Phone No.	May Bring Child	May be Informed of Patient's Info.	Consent To Treatment Changes
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no
_____	_____	_____	yes / no	yes / no	yes / no

* Father, mother, step-parent, grandparent, older sibling, baby sitter, aunt, etc.

Financial Arrangements:

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected in full at each appointment, unless prior arrangements have been made.

☐ Cash ☐ Personal Check ☐ Credit Card

Late or Unpaid Payments:

I understand that failure to keep this account current may result in your office being unable to provide additional dental services except for genuine dental emergencies or where there is a prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonal attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. I further understand that there is a [redacted] service fee for all returned checks. My insurance company, if any, is not responsible for paying this fee.

Authorization and Release:

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 health practitioners.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree that I am ultimately responsible for payment of all services rendered on behalf of my child.

I warrant that I am the child's legal guardian and am authorized to provide the above information and consent to the child's treatment at this dental office.

X _____ _____

Signature of legal guardian (or patient, if of age) Today's Date