Welcome

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

Dr. Nichols, Family Dentistry

*Today's Date*_____

Your Child

Child's Name_____

Nickname_____ Sex_____

Birthdate_____ Age_____

School_____ Grade_____

Child's Home Address_____

City_____ State_____ Zip_____

Phone_____

Responsible Party

Name_____

Relationship_____

Address_____

City_____ State_____ Zip_____

Email_____

SS#_____

Who is responsible for making appointments?

Name_____

Home Phone_____Cell Phone_____

Work Phone_____ Ext._____

Best Time to Call_____

Time_____Days_____

_____

Mother ☐ Stepmother ☐ Guardian

Name_____

Home Phone_____Cell Phone_____

Work Phone_____ Ext._____

Email_____

Employer_____

Occupation_____

SS#_____

Martial Status ☐Single ☐ Married ☐Divorced ☐Widowed ☐Separated

Father ☐ Stepfather ☐ Guardian

Name_____

Home Phone_____Cell Phone_____

Work Phone_____ Ext._____

Email_____

Employer_____

Occupation_____

SS#_____

Martial Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Primary Insurance

Insured's Name_____

Relationship_____

Birthdate_____ SS#_____

Employer_____

Occupation_____

Insurance Company_____

Group#_____Employee#_____

Ins. Co. address_____

City_____ State_____ Zip_____

Additional Insurance

Insured's Name_____

Relationship_____

Birthdate_____SS#_____

Employer_____

Occupation_____

Insurance Company_____

Group#_____ Employee#_____

Ins.Co. address_____

City_____ State_____ Zip_____

Financial Arrangements

For your convenience, we offer the following methods of payment. How will you be paying today?

☐Cash ☐Personal Check ☐Outside Financing Care Credit

Credit Card ☐Visa ☐MC ☐Discover

Dental Health History *CONFIDENTIAL*

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?_____

Is your child's water flouridated?.....☐Yes ☐No Does Your child take fluoride supplements?.....☐Yes ☐No

Does your child:

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

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

Clench jaws.....☐Yes ☐No

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 Hospitalization/Surgeries/Serious Illnesses? When?

_____

_____

_____

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

_____

_____

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

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

_____

Does your child have or have they ever had any of the following:

Asthma.....☐Yes ☐No Stomach, liver or kidney problems.....☐Yes ☐No

Cancer.....☐Yes ☐No Handicaps/Disabilities.....☐Yes ☐No

Hepatitis.....☐Yes ☐No Tuberculosis.....☐Yes ☐No

HIV/AIDS.....☐Yes ☐No Diabetes.....☐Yes ☐No

Hemophilia.....☐Yes ☐No Rheumatic Fever.....☐Yes ☐No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks).....☐Yes ☐No

Congenital Heart Defect.....☐Yes ☐No

Heart Murmur.....☐Yes ☐No

Convulsions/Epilepsy.....☐Yes ☐No

Abnormal Bleeding.....☐Yes ☐No Smoking or Smokeless Tobacco use.....☐Yes ☐No

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 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/guardian if minor) Date

_____ _____

Signature of Dentist Date