WELCOME

1 about your child

Today's Date: ____ /____ /____ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ☐ Boy ☐ Girl

Child's Birthdate: ____ /____ /____ Age: _____

School: _____ Grade: _____

Child's Home Phone # (_____) _____

Child's Home Address: _____

_____
CITY STATE ZIP

Referred by: _____
(If doctor, please give phone number & address.)

Phone #: (_____) _____

Address: _____

_____
CITY STATE ZIP

2 insurance information

Primary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: __ /__ /__

Insured's Employer: _____

Secondary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: __ /__ /__

Insured's Employer: _____

Does either policy cover Orthodontics? ☐ **Yes** ☐ **No**

3 child's family information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ☐ Yes ☐ No

How many Brothers/Sisters? _____ Age(s): ___, ___, ___

Mother's Name: _____
☐ STEPMOTHER ☐ GUARDIAN

Home Address _____
(☐ CHECK IF SAME AS CHILD'S)

_____
CITY STATE ZIP

(_____) _____ (_____) _____ _____
HOME PHONE # WORK PHONE # EXT

_____ __ / __ / __ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC #

Employer: _____ How Long: _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
☐ STEPFATHER ☐ GUARDIAN

Home Address _____
(☐ CHECK IF SAME AS CHILD'S)

_____
CITY STATE ZIP

(_____) _____ (_____) _____ _____
HOME PHONE # WORK PHONE # EXT

_____ __ / __ / __ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC #

Employer: _____ How Long: _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 account information

Person ultimately responsible for account

_____ _____
FULL NAME RELATION TO CHILD

Billing Address _____

_____
CITY STATE ZIP

_____ __ / __ / __ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC #

(_____) _____ ___ (_____) _____
WORK PHONE # EXT CELL PHONE #

Email Address _____

please continue on back

7621 Trenholm Road Ext • Columbia SC 29223 • 803.699.9989

5 child's dental information

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Last Dental exam: _____ / _____ / _____ Last Dental X-rays: _____ / _____ / _____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ☐ Yes ☐ No ☐ Don't know

How would you rate the child's smile? (circle one) Worst 1 2 3 4 5 6 7 8 9 10 Best

6 child's medical history

Is Child taking any of the following medications? ☐ Pain killers (INCLUDING ASPIRIN) ☐ Ritalin ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: _____

Child's Physician: _____ (_____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE #

Address _____ Last Medical Exam ____/____/____
CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	Y N Tonsillitis	Y N High/Low Blood Pressure
Y N Rheumatic Fever	Y N Respiratory Problems	Y N Hepatitis
Y N Artificial Heart Valves	Y N Asthma/Difficulty Breathing	Y N Artificial Bones/Joints/Implants
Y N Congenital Heart Defect	Y N Blood Transfusion(s)	Y N Liver/Kidney/Organ Problems
Y N Scarlet Fever	Y N Leukemia/Anemia	Y N HIV+/AIDS/ARC
Y N Surgeries/Operations	Y N Diabetes/Hypoglycemia	Y N Tuberculosis TB
Y N Cancer/Tumors	Y N Hemophilia	Y N Psychiatric Problems
Y N Chemotherapy	Y N Abnormal Bleeding	Y N Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	Y N Cleft Lip/Palate	Y N Fainting/Seizures/Epilepsy
Y N Hearing Problems	Y N Birth Defects	Y N Cerebral Palsy

Please list any other medical condition(s) child has or ever had: _____

Is Child allergic to: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Novocaine) ☐ Aspirin ☐ Food allergies ☐ Other(s): _____

Please rate the child's general health from 1-10: ____ Does child wear contact lenses? ☐ Yes ☐ No

Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

☐ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

☐ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____ / _____ / _____
☐ Parent or Guardian ☐ Other

UPDATE
(OFFICE USE)

_____ __/__/__
Initials Date
Comments

_____ __/__/__
Initials Date
Comments

_____ __/__/__
Initials Date
Comments