Dental Information_____

Please describe the reason for today's visit_____

_____

Is this Child/Minor first visit to the dentist? Yes ☐ No ☐

If no, when was the last visit and what was done at that visit_____

Has Child/Minor complained of any dental problems? Yes ☐ No ☐

If yes, please describe_____

Has Child/Minor experienced any unpleasant dental experiences? Yes ☐ No ☐

If yes, please describe_____

Does Child/Minor have any oral habits? Yes ☐ No ☐

If yes, please circle thumb sucking nail biting mouth breathing pacifier sleeping with bottle

Was Child/Minor breast fed? Yes ☐ No ☐ Until what age?_____

Was Child/Minor bottle fed? Yes ☐ No ☐ Until what age?_____

Does Child/Minor grind their teeth? Yes ☐ No ☐ If so, when?_____

Are ***you*** nervous about today's visit? Yes ☐ No ☐ If so, why?_____

_____

Does Child/Minor's gums bleed when brushed or flossed? Yes ☐ No ☐

Does Child/Minor use Fluoride products? Yes ☐ No ☐

Fluoride drops, tablets or rinse (please circle)

Do you use Fluoridated water? Yes ☐ No ☐

How often does Child/Minor brush their teeth? _____

How often does Child/Minor floss their teeth? _____

Do you assist Child/Minor with brushing and flossing? _____

Doctor Signature_____Date_____

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform the doctor if my Child/Minor has a change in health.

Child/Minor Consent

I am the parent, guardian or legal representative of (minor's name)_____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with (Insurance Company)_____ and assign directly benefits to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above-named doctor may use my child's health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end then the current treatment plan is completed or one year from the date signed below.

Date_____ Guardian Name (Print)_____Relationshi to Patient_____

Signature_____