Bryant
FAMILY DENTISTRY

PEDIATRIC PATIENT INFORMATION & HEALTH HISTORY:

Child's Name: _____ Date: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____

Father's Name: _____ Mother's Name: _____

Father Employed By: _____ Mother Employed By: _____

Who is financially responsible for child? _____

Parent's Social Security #: _____ Email Address: _____

Name of your Dental Insurance Company: _____

Home Phone #: _____ Cell Phone #: _____

Home Address: _____

_____

City State Zip

Child's Favorite Hobby: _____

Whom may we thank for referring you? _____

Authorization & Release:

I certify that I have read and understand the following information to the best of my knowledge. The questions have been accurately answered to the best of my ability. I understand that providing incorrect information can be dangerous to my child's health. 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 the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for my services.

I AGREE TO BE RESPONSIBLE FOR THE TOTAL PAYMENT FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS, REGARDLESS OF WHAT MY INSURANCE COMPANY PAYS. I AGREE TO BE RESPONSIBLE FOR ANY FEES INCURRED SHOULD MY ACCOUNT BECOME DELINQUENT. THIS INCLUDES A 40% COLLECTION FEE AND ATTORNEY/COURT COSTS SHOULD THEY BE NECESSARY FOR COLLECTION OF MY DEBT.

Parent or Guardian's Signature: _____

MEDICAL HISTORY:

Your child's medical history plays an important role in the health of their mouth and can determine the safety and effectiveness of anesthetics and other medications used for their dental treatment.

Please take the time to carefully and accurately answer the following questions.

Child's Physician's Name: _____ Date of Last Exam: _____

Does your child have any of the following medical conditions?

___ Any heart problems	___ Circulatory Problems	___ Excessive Bleeding
___ Allergies to anesthetics	___ Allergies to _____	___ Asthma
___ Diabetes	___ Autoimmune Disorder	___ Ulcers
___ Allergies to medicines or drugs	___ Anemia	___HIV/AIDS
(Penicillin, etc.)	___ Tonsillitis	___ Mitral Valve Prolapse
___ Hepatitis	___ Radiation Treatments	___ Hearing impairment
___ Sinus issues	___ Psychiatric Care	___ Vision impairment
___ Cancer	___ Tuberculosis	___ Other (describe below)

Please **list all medications** your child is currently taking & describe any **current, past,** or **upcoming medical treatments** or **surgeries**.

_____
_____
_____

DENTAL Q & A:

Is your child having any pain or discomfort at this time? _____

Date of last dental visit: _____ Has your child had an unpleasant dental experience? _____

Has your child had any injuries to their mouth, teeth, or head? _____

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier use? _____

Do you have any concerns about your child's smile or oral health? _____

Does your child fear dental treatment? _____ Does your child use any fluoride? _____

Does your child brush their teeth daily? _____ Does your child floss daily? _____

Do you assist your child with their oral health routine? _____

Parent or Guardian's Signature: _____Date: _____