Children's dental ark

child's general information

Date.....

NAME..... AGE..... DATE OF BIRTH..... ❑ MALE ❑ FEMALE

ADDRESS..... CITY..... STATE..... ZIP.....

PHONE..... REFERRED BY.....

ANY SIBLINGS SEEN BY US.....

SCHOOL..... GRADE.....

HOBBIES.....

family information

FATHER (OR CARETAKER).....

SSN.....DATE OF BIRTH.....

ADDRESS.....

CITY..... STATE..... ZIP.....

PHONE (H).....CELL.....WORK.....

EMPLOYER.....

OCCUPATION.....

EMAIL.....

MOTHER (OR CARETAKER).....

SSN.....DATE OF BIRTH.....

ADDRESS.....

CITY..... STATE..... ZIP.....

PHONE (H).....CELL.....WORK.....

EMPLOYER.....

OCCUPATION.....

EMAIL.....

insurance & account information

INSURED'S NAME..... RELATIONSHIP TO CHILD.....

INSURANCE COMPANY NAME..... PHONE.....

ADDRESS.....

SUBSCRIBER # / SSN..... GROUP #..... POLICY #.....

I hereby authorize assignment of my insurance rights and benefits directly to Children's Dental Ark for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company. I also understand that I am responsible for reporting any changes in my insurance coverage.

Signature ..... Date.....

child's dental history

DATE OF LAST DENTAL EXAM..... NAME OF DENTIST..... SERVICES RENDERED.....

TEETH OR JAW INJURIES..... WHEN .....

HISTORY OF DENTAL PAIN OR SWELLING? PLEASE EXPLAIN.....

HISTORY OF ANY OF THE FOLLOWING?

❑ thumb/fingersucking ❑ pacifier ❑ lip or nail biting ❑ headaches ❑ grinding/clenching ❑ jaw pain ❑ nursing/bottle after 12-14 months ❑ speech problems

HOW OFTEN DOES YOUR CHILD BRUSH?..... DO YOU ASSIST HIM/HER?..... FLOSSING?.....

DOES YOUR CHILD RECEIVE

❑ fluoridated drinking water ❑ bottled water ❑ well water ❑ fluoride tablets/drops ❑ fluoride toothpaste and/or rinse

DO YOU HAVE A REVERSE OSMOSIS WATER FILTERING SYSTEM? .....

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?.....

child's medical history

CHILD'S PHYSICIAN..... CITY / STATE..... PHONE.....

DATE OF LAST PHYSICAL EXAM..... RESULTS..... IMMUNIZATIONS UP TO DATE? ❑ YES ❑ NO

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN NOW?	❑ YES ❑ NO	Medications .....
RECEIVING ANY MEDICATION OR DRUGS?	❑ YES ❑ NO	.....
EVER BEEN HOSPITALIZED?	❑ YES ❑ NO	.....
EVER HAD SURGERY?	❑ YES ❑ NO	Allergies .....
EXCESSIVE BLEEDING WHEN CUT?	❑ YES ❑ NO	.....

HAS YOUR CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH, ANY OF THE FOLLOWING?

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Asthma
- ❑ Cancer
- ❑ Thyroid Disease
- ❑ Developmental/Behavorial Problems
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Convulsions
- ❑ Hepatitis
- ❑ Bladder Problems
- ❑ Epilepsy
- ❑ Fainting
- ❑ Measles
- ❑ Mumps
- ❑ Heart Problems
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Hearing Problems
- ❑ ADD/ADHD
- ❑ Bleeding Disorder
- ❑ Other .....

consent for treatment & x-rays

I give the doctor(s) permission to use such measures as deemed necessary in their professional judgment to render diagnosis and treatment for my child. This may include oral examinations, x-rays, use of other diagnostic aids, cleaning of teeth, application of fluoride, application of preventive sealants, restoration and/or removal of teeth, and use of local anesthesia and/or sedative medications.

I have given an accurate report of my child's physical and mental health history. I have reported any prior reactions to drugs, systemic diseases, abnormal bleeding, or any other conditions that my child's medical doctor has advised me to report to a dentist. I further understand that it is my responsibility to inform Children's Dental Ark of any changes in my child's medical status.

Signature ..... Date.....

financial agreement

I understand that I am responsible for payment of all services as rendered, and that all balances are due at the time of each treatment visit.

Signature ..... Date.....