Welcome To Treasured Smiles Pediatric Dentistry
Patient Forms

Today's Date:_____________
Patients Full Name:____
LAST FIRST M.I.
Patients Nickname:_____________________Date of Birth:____________ □ M □ F
Child's School:__________________ Grade:________
Child's Home Phone:__________________ Social Security #:_____________________
Child's Home Address:____
Street City State Zip
How did you hear about our office?____

Does your child have or ever had any of the following medical conditions?

Y N Heart Murmur
Y N Rheumatic fever
Y N Artificial Heart Valves
Y N Congenital Heart defect
Y N Scarlet Fever
Y N Surgeries/Operations
Y N Cancer/Tumors
Y N Chemotherapy
Y N Jaw problem TMJ/TMD
Y N Hearing problem
Y N Tonsillitis
Y N Respiratory problems
Y N Asthma
Y N Blood Transfusion
Y N Leukemia/Anemia
Y N Diabetes/hypoglycemia
Y N Hemophilia
Y N Abnormal bleeding
Y N Cleft lip/palate
Y N Birth defects
Y N High/low blood pressure
Y N Hepatitis
Y N Artificial Bones/Joints
Y N Organ Problems
Y N HIV/AIDS/ARC
Y N Tuberculosis TB
Y N Psychiatric Problems/Autism
Y N Hyperactive ADD
Y N Fainting/seizures/epilepsy
Y N Cerebral Palsy

Please list any other medical condition(s)______________________________________

Is Child taking any of the following medications? Pain Killers□ (including ASPIRIN) □ Ritalin □
Asthma Medication □ Insulin □ Others □ :_______________________________________
Any allergies to: Latex □ Penicillin/Amoxicillin□ Tetracycline □ Novocaine □ Aspirin□
Food allergies□ Others□ :_____________________

Has this Child ever taken the drug Ritalin? No□ Yes□ /How long?___________

Dental History

Last Dental Visit __/__/____

Dental Concerns:

Thumb sucking Tongue Sucking □ Nail Biting□ Grinding of teeth □ Bottle usage □

Pacifier □

Fluoride toothpaste: **Y N**

How often do you floss? ______________________

How often do you brush? _________________________

Who is accompanying this child today?
_____________________________________ __________________

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

PLEASE INCLUDE AT LEAST 2 CONTACT NUMBERS
Do have legal Custody of this child? Yes□ No □

Mother's Name:____
□ Guardian
Mother's Home Address:____
□ CHECK IF SAME AS CHILD'S) Street City State Zip
Home Phone______________Work Phone_______________ **Cell Phone____________**
Email address: ____
Mother's Social Security Number______-_____-________ Date of Birth____/____/____
Mother's Employer:____________________________Occupation:_________________

Father's Name:____
□ Guardian
Father's Home Address:____
(□ CHECK IF SAME AS CHILD'S) Street City State Zip
Home Phone______________Work Phone_______________ **Cell Phone____________**
Email address: ____
Father's Social Security Number ______-_____-________ Date of Birth____/____/____
Father's Employer:________________________________Occupation:__________________

Primary Dental Insurance
Policy Holder's Full Name:_______________________________________
Policy Holder's SSN#:____
ID # on the card:____
Date of Birth: ______/_______/_______
Name of Employer:____
Group Number:________________________
Relation to patient:__________________
Name of Insurance Company and address:______________________________________
____
Street City State Zip
Insurance Company Phone:(______)_________-______________

Secondary Dental Insurance
Policy Holder's Full Name:_______________________________________
Policy Holder's SSN#:____
ID # on the card:____
Date of Birth: ______/_______/_______
Name of Employer:____
Group Number:________________________
Relation to patient:__________________
Name of Insurance Company and address:______________________________________
____
Street City State Zip
Insurance Company Phone:(______)_________-______________

Person ultimately responsible for account

Name:______________________________________ _________________________

Relation to child

Billing Address:____

☐ CHECK IF SAME AS ABOVE) Street City State Zip

_______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for **Initials** services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

❖ 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 prior to treatment. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in the 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 ☐