PATIENT HISTORY

Today's Date _____
Child's Name _____
Nickname _____ Age _____
Birth Date _____ F___ M___
Home Address _____
City _____ ST _____ Zip _____
School _____ Grade _____
Father's Name _____
Mother's Name _____
Father Employed By _____
How Long? _____
Position _____
Father's Home Phone _____
Business Phone _____
Father's SS# _____
Mother Employed By _____
How Long? _____
Position _____
Mother's Home Phone _____
Business Phone _____
Mother's SS# _____
Whom may we thank for referring you? _____

THIS ACCOUNT WILL BE PAID BY
❑ CASH ❑ CHECK ❑ CREDIT CARD
❑ DEBIT CARD (PATIENT LIABILITY)

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT OTHER THAN ABOVE NAMED PATIENT

Responsible Party's Name _____
SS# _____
Birth Date _____ Age _____ F___ M___
Address _____
City _____ ST _____ Zip _____
Phone _____
Responsible Party's Employer _____
Position _____ How Long? _____
Employer's Address _____
Employer's Phone _____

DENTAL INSURANCE INFORMATION FOR CHILD

Subscriber's Name _____
Birth Date _____ SS# _____
Subscriber's Employer _____
Employer's Address _____
Insurance Company _____
Address _____
Group No. _____
Have you used the dental insurance previously? ❑ Y ❑ N
Is the child covered by more than one dental plan? ❑ Y ❑ N

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____
Birth Date _____ SS# _____
Subscriber's Employer _____
Address _____ Phone _____
Insurance Co. _____
Address _____
Group No. _____

I authorize all of the above information to be used as needed by the dental office to facilitate this child's dental treatment. I understand that I am financially responsible for the dental expenses of this child. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGNATURE _____ **DATE** _____
RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS

I, _____ hereby assign all dental benefits to Brauer Family Dentistry. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

SIGNATURE _____ **DATE** _____
RESPONSIBLE PARTY

HEALTH HISTORY

Child's Physician _____

Phone _____

Date of Last Examination _____

Results _____

Is this child under the care of a physician now? ❑ Y ❑ N

Receiving any medication or drugs? ❑ Y ❑ N

Have any excessive bleeding when cut? ❑ Y ❑ N

Even been hospitalized? ❑ Y ❑ N

Allergic to Penicillin or any other drug? ❑ Y ❑ N

If yes, explain_____

_____

Does this child have any history of or difficulty with any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Asthma
- ❑ Bladder
- ❑ Cerebral Palsy
- ❑ Chicken Pox
- ❑ Chronic Sinus
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hearing
- ❑ Heart
- ❑ Hepatitis
- ❑ Kidney
- ❑ Liver
- ❑ Malignancies
- ❑ Mastoid
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Rheumatic Fever
- ❑ Thyroid
- ❑ Tuberculosis
- ❑ Other, Explain

Please describe any current treatment including drugs, pending surgery, recent injuries or any other information this office should be aware of. _____

_____

May we request release of this child's medical records for our reference? ❑ Y ❑ N

This information was given by _____

Relationship to child _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service? _____

Has child complained about dental problems? ❑ Y ❑ N

Explain _____

Any unhappy dental experiences? ❑ Y ❑ N

Explain _____

Any injuries to mouth – teeth – head? ❑ Y ❑ N

Explain _____

Any mouth habits – thumb sucking, nail biting, nursing bottle habits, pacifier, etc.? ❑ Y ❑ N

Explain _____

Any unusual speech habits? ❑ Y ❑ N

Explain _____

Any lost teeth? ❑ Y ❑ N

Explain _____

Have teeth been replaced? ❑ Y ❑ N

Explain _____

Orthodontic appliances worn now or before? ❑ Y ❑ N

Explain _____

Does your child brush teeth daily? ❑ Y ❑ N

Explain _____

Do you assist child with tooth brushing? ❑ Y ❑ N

How often? _____

Is dental floss used? ❑ Y ❑ N

How often? _____

Are disclosing tablets used? ❑ Y ❑ N

Is fluoride taken in any form? ❑ Y ❑ N

Child's attitude towards dentistry_____

_____

Do you desire complete dental service? ❑ Y ❑ N

Explain _____

SUMMARY (for doctor's use) _____

_____

_____

_____