WELCOME

Print Form

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ _____ _____ Date of Birth _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex _____ Soc. Sec. # _____ School _____

Grade _____ Hobbies/Sports _____

Father's Name _____ Mother's Name _____

Whom may we thank for referring you? _____

Notify in case of emergency _____

Cell Phone _____ Home Phone _____

PRIMARY INSURANCE / RESPONSIBLE PERSON

Person Responsible for Account _____ _____ _____
Last Name *First Name* *Initial*

Relation to Child _____ Date of Birth _____ Soc. Sec. # _____

Address *(if different from child)* _____ Home Phone _____

City _____ State _____ Zip _____

Person responsible Employed by _____ Occupation _____

Business Phone _____ Insurance Company _____

Group # _____ Phone _____

Subscriber # _____ Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Date of Birth _____

Address *(if different from child)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Person responsible Employed by _____

Occupation _____ Business Phone _____

Insurance Company _____ Phone _____

Group # _____ Subscriber # _____

Name of other dependents under this plan _____

I, _____, the parent or legal guardian of my child, _____ authorize and consent to routine and emergency dental treatment for my child when deemed necessary by Dr. Swisher and his staff. This authorization will be in effect until revoked in writing by me. Otherwise, I understand that I need to be present during the entire length of my child's dental appointment.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient/Guardian Signature: _____ **Relationship:** _____ **Date** _____

Payment is due at time of treatment, unless prior arrangements have been approved.

DENTAL HISTORY

Child's Name _____ _____ _____ Age _____ Date of Birth _____

Last Name *First Name* *Initial*

What would you like us to do for your child today? _____

Former Dentist _____ Date of last dental x-rays _____

How often does your child brush? _____ Floss? _____

Has your child ever experienced a mouth or chin injury? ☐ Yes ☐ No

Does your child have speech problems? ☐ Yes ☐ No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

If yes, please describe _____

Child's habits affecting the mouth or teeth ☐ Thumb sucking ☐ Mouth breather ☐ Other _____

Other information about your child's dental health or previous treatment _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Is your child currently under physician care? ☐ Yes ☐ No If yes, describe _____

Are your child's immunizations current? ☐ Yes ☐ No

Has your child had any of the following?

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Blood disease
- ☐ Cancer
  - Type _____
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy
- ☐ Cough, persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Hearing impairment
- ☐ Heart problems
  - Describe _____
- ☐ Hemophilia/Abnormal bleeding
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Respiratory disease
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Thyroid disease or malfunction
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Other
  - Describe _____

List medications your child is taking, if any:

_____

_____

List drug allergies, If yes, list all:

_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I understand this information is confidential and will not be released without my signed consent.

Patient/Guardian Signature: _____ **Relationship:** _____

Date		Same		Intl		Changes	
Date		Same		Intl		Changes	
Date		Same		Intl		Changes	
Date		Same		Intl		Changes	