Child

WELCOME

HILTON FAMILY DENTISTRY

1 About Your Child

Today's Date: ____/____/____ File #: ________

Child's Name: ________________
LAST FIRST M.I.

Child's Nickname: ________________ ❑Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: ________

School: ________________ Grade: ________

Child's Home Phone #: ( ) ________________

Child's SS #: ________________

Child's Address: ________________

CITY STATE ZIP

Referred By: ________________
(If doctor, please give address and phone number)

2 Insurance Information

Primary Dental Insurance

Co. Name: ________________

Address: ________________

CITY STATE ZIP

Phone #: ( ) ________________

Insured's ID#: ________________

Group # (Plan, Local or Policy #): ________________

Insured's Name: ________________

Relation: ________________ Date of Birth: ____/____/____

Insured's Employer: ________________

Secondary Dental Insurance

Co. Name: ________________

Address: ________________

CITY STATE ZIP

Phone #: ( ) ________________

Insured's ID#: ________________

Group # (Plan, Local or Policy #): ________________

Insured's Name: ________________

Relation: ________________ Date of Birth: ____/____/____

Insured's Employer: ________________

Please continue on back

Hilton Family Dentistry • 10 Canning Street • Hilton, NY 14468
585-392-6440 • www.hiltonfamilydentistry.com

3 Child's Family Information

Who is accompanying this child today? ________________

FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Who is accompanying this child today? ________________

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ________ Age(s): ________

MOTHER'S NAME ❑ STEP MOTHER ❑ GUARDIAN EMAIL ADDRESS

❑ CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

( ) ( )
HOME PHONE # WORK PHONE # EXT.

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ________________ How Long? ________

EMPLOYER'S ADDRESS CITY STATE ZIP

FATHER'S NAME ❑ STEP FATHER ❑ GUARDIAN EMAIL ADDRESS

❑ CHECK IF SAME AS CHILD'S HOME ADDRESS CITY STATE ZIP

( ) ( )
HOME PHONE # WORK PHONE # EXT.

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ________________ How Long? ________

EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ________________
RELATION TO CHILD

Billing Address: ________________

CITY STATE ZIP

SOCIAL SECURITY #: ________________ DATE OF BIRTH ____/____/____

DRIVERS LIC. # ________________

WORK PHONE #: EXT. CELL PHONE #.

Payment method: ❑Cash ❑Check

❑Credit Card - Enter card # above (if accepted) ________________

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

5 Dental Information

Reason for today's visit: ❑Exam ❑Emergency ❑Consultation Is Child in pain? ❑No ❑Yes How Long? ________

Please indicate ☑ any of the following problems:

- ❑Discomfort, clicking or popping in jaw
- ❑Red, swollen or bleeding gums
- ❑Sensitive tooth, teeth or gums
- ❑Blisters/Sores in or around the mouth
- ❑Lost/Broken Filling(s)
- ❑Teeth Grinding
- ❑Ringing in Ears
- ❑Broken/Chipped tooth
- ❑Stained Teeth
- ❑Locking Jaw
- ❑Bad Breath
- ❑Loose Tooth
- ❑Other: ________

Does child require pre-medication? ❑Yes ❑No ❑Don't Know

Previous Dentist: ________ ( ) ________
Name Phone #

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day child brushes: ____ Times a week child flosses? ____ Is the child's water fluoridated: ❑Yes ❑No

How would you rate the child's smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 Medical History

Is Child taking any of the following medications? ❑ Pain killers (including aspirin) ❑Ritalin
❑Stimulants ❑Blood Thinners ❑Tranquilizers ❑Insulin ❑Others: ________

Child's Physician: ________ ( ) ________
DOCTOR'S NAME OR CLINIC NAME PHONE#

Have you ever taken: Bisphosponates (ex. Aredia/Fosamax) ❑Yes ❑ No Phen-fen/Redux ❑Yes ❑No

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N AIDS/HIV Positive	Y N Stroke	Y N Easily Winded	Y N Osteoporosis	Y N Shingles
Y N Alzheimer's Disease	Y N Cancer	Y N Emphysema	Y N Pain in Jaw Joints	Y N Fainting Spells/Dizziness
Y N Anaphylaxis	Y N Chemotherapy	Y N High Cholesterol	Y N Ulcers	Y N Frequent Cough
Y N Anemia	Y N Heart Attack/Failure	Y N Hives or Rash	Y N Venereal Disease	Y N Frequent Headaches
Y N Angina	Y N Heart Murmur	Y N Asthma	Y N Hemophilia	Y N Low Blood Pressure
Y N Epilepsy or Seizures	Y N Heart Pacemaker	Y N Blood Disease	Y N Hepatitis A	Y N Lung Disease
Y N Excessive Bleeding	Y N Psychiatric Care	Y N Stomach/Intestinal Disease	Y N Hepatitis B or C	Y N Mitral Valve Prolapse
Y N Hypoglycemia	Y N Cortisone Medicine	Y N Bruise Easily	Y N Herpes	Y N Tuberculosis
Y N Sinus Trouble	Y N Diabetes	Y N Glaucoma	Y N High Blood Pressure	Y N Tumors or Growths
Y N Leukemia	Y N Drug Addiction	Y N Hay Fever	Y N Scarlet Fever	Y N Convulsions

Please list any other medical condition(s) child has ever had: ________

Is Child allergic to: ❑Latex ❑Penicillin / Amoxicillin ❑Tetracycline ❑Dental Anesthetics (Novocaine)
❑Aspirin ❑Food Allergies ❑Other(s): ________

Please rate the child's general health from 1-10: ______ Does the child wear contact lenses? ❑Yes ❑No

Has the child ever taken the drug Ritalin: ❑ No ❑Yes/How long? ______ Child's blood type: ______

Does this child do any of the following: ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/ Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- 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. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in 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.

____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature ________ Date ___/___/___
❑ Parent or Guardian

UPDATE
OFFICE USE

___ ___/___/___
Initials Date
____
Comments

___ ___/___/___
Initials Date
____
Comments

___ ___/___/___
Initials Date
____
Comments