Child

WELCOME

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

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) _____

_____ 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).
Initials

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

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	❑Lost/Broken Filling(s)	❑Stained Teeth
❑Red, swollen or bleeding gums	❑Teeth Grinding	❑Locking Jaw
❑Sensitive tooth, teeth or gums	❑Ringing in Ears	❑Bad Breath
❑Blisters/Sores in or around the mouth	❑Broken/Chipped tooth	❑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: Bisphosphonates (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