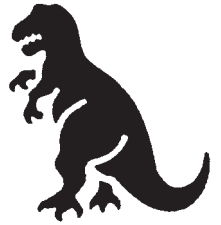




Welcome

Gentle Dental Care

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The Benefits of a happy healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. The better we communicate, the better we can care for you. Please fill out these forms completely.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

1. ABOUT YOUR CHILD

Name: _____

Nickname: _____

Birthdate: ____/____/____ Male Female

Social Security #: _____

Special interests, sports or hobbies: _____

Physical Address: _____

City, State, Zip: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____

Referred By: _____

2. PARENT - ADULT INFO

Your Name: _____

Social Security #: _____

Relationship to child: _____

Your home phone and address, if different from child's:

Occupation: _____

Employer: _____

Work Phone: _____ Ext. _____

Cell Phone: _____

3. DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: _____ Insured's SS#: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK#: _____ HM#: _____

Person Responsible for Account: _____

WK#: _____ Ext. _____ HM# _____

Billings Address: _____

Relationship: _____ SS#: _____

Employer: _____ DL#: _____

4. DENTAL MEDICAL HISTORY

Has your child been to the dentist before? No Yes

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of at present?

No Yes If yes, please explain: _____

Does your child brush his/her teeth daily? No Yes

Please rate your child's oral health: Good Fair Poor

Is your child currently under the care of a physician? No Yes

Child's physician: _____

Their phone #: _____

The approximate date of last visit: _____

Please rate your child's medical health: Good Fair Poor

Is your child allergic to any drugs? No Yes

If yes, please list: _____

Does your child need to be premedicated before dental treatment?

No Yes

Allergies

_____ Aspirin	_____ Local Anesthetic
_____ Codeine	_____ Penicillin
_____ Iodine	_____ Sulfa
_____ Latex	

Has your child ever had any of the following diseases or medical problems?

Y N Heart Murmur

Y N Heart problems of any kind

Y N Convulsions

Y N Cancer

Y N Diabetes

Y N Epilepsy

Y N Rheumatic Fever

Y N Scarlet Fever

Y N HIV+/AIDS

Y N Hemophilia

Y N Hepatitis: If yes, type: _____

Y N Bleeding problems of any kind

Y N Hearing impairment

Y N Hyperactive

Y N Any operations

Y N Any stays in hospital. Explain: _____

Are there any other medical conditions or problems relating to your child? No Yes

If yes, please list:

FEMALES

Are you pregnant? Yes No Are you Nursing? Yes No Are you using contraceptives? Yes No

If so, due date: _____

I understand I am responsible for my account regardless of my insurance. I also understand that me insurance is an agreement between my insurance company and me.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use to my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment for benefits. I authorize the use of this signature on all insurance submissions.

Signature of parent or guardian _____ Date _____