Welcome

Please take a few minutes to fill out the questionnaire.
Thank you very much for your attention

Patients Name: ____ **Nickname:** ________________________
Last First MI

Date of Birth: ________________________ **Gender:** ________________

Patients Address: _____________________________ **City:** ___________________ **State:** _________ **Zip:** ________

Parents Cell Phone: __________________________ **E-mail:** ____

Home Phone: ______________________________ **Parents Work Phone:** _______________________________

In case of emergency, contact __________________________________ **Phone:** __________________________

Whom may we thank for referring you? ____

Who Is Accompanying the Patient Today? Name: _________________________ **Relation:** ____________________

Do you have legal joint custody (Appointed by court) of this patient? Yes No If Yes, documents are required

Parents Marital Status: Single Married Widowed Divorced Separated

Person Responsible for Account

Name: ____ **Relation:** ___________________

Name: ____ **Relation:** ___________________

Address (If Different): ___________________________ **City:** ____________ **State:** ________ **Zip:** ________

Parents Cell Phone: __________________________ **E-mail:** ____

Home Phone: ______________________________ **Parents Work Phone:** _______________________________

Name of Employer: _____________________________ **DL#:** _____________________ **SS#:** _______________

Who is responsible for making appointments? Name: ______________________ **Cell Phone:** ____________________

Primary Dental Insurance
Insurance Co Name: ________________________
Insurance Co Address: ______________________
Insurance Co Phone: ________________________
Group #: _________________________________
Policy Owners Name: _______________________
Relationship to Patient: _____________________
Policy Owner Birthdate: ___________ **ID#:** ________

Orthodontic Coverage? Yes No

Secondary Dental Insurance
Insurance Co Name: ________________________
Insurance Co Address: ______________________
Insurance Co Phone: ________________________
Group #: _________________________________
Policy Owners Name: _______________________
Relationship to Patient: _____________________
Policy Owner Birthdate: ___________ **ID#:** ________

Orthodontic Coverage? Yes No

Dental History

Reason for Today's Visit____is this your child's first visit to the dentist? Yes / No
Date of Last Dental Care____Date of Last X-rays _________________________

Does your child have any of the following?

- ☐ Lip Sucking / Biting
- ☐ Speech Problems
- ☐ Nail Biting
- ☐ Thumb/Finger Sucking
- ☐ Mouth Breather
- ☐ Tongue Thrust
- ☐ Nursing Bottle Habits
- ☐ Grinding Teeth

1. Does the patient brush his / her teeth daily? Yes No
2. Does the patient floss his / her teeth daily Yes No
3. Has the patient ever had orthodontic treatment (braces)? Yes No
4. Has the patient ever had a serious / difficult problem associated with previous dental work? Yes No
5. Has the patient ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Yes No

Medical History

1. Is the patient currently under the care of a physician? Yes No
2. Has the child ever been hospitalized? Yes No
3. Is the child physically, mentally or emotionally impaired? Yes No
4. Describe the patient's current physical health: Good Fair Poor

PLEASECHECK AT LEAST ONE (1) OF THE BOXES)

Has the patient ever had any of the following medical problems or conditions? Please check at least one of the boxes.

☐ No Medical Problems

- ☐ ADD / ADHD
- ☐ Anemia
- ☐ Artificial Bones / Joints
- ☐ Asthma
- ☐ Autism
- ☐ Cancer
- ☐ Congenital Heart Defect / Heart Murmur
- ☐ Convulsions/ Epilepsy/ Seizures
- ☐ Bleeding Disorders
- ☐ Diabetes
- ☐ Disabilities:_________________________
- ☐ Hearing Impairment
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV+ / AIDS
- ☐ Kidney / Liver Problems
- ☐ Operations / Surgery: ____________________
- ☐ Rheumatic / Scarlet Fever
- ☐ Sickle Cell Disease / Traits
- ☐ Thyroid
- ☐ Tuberculosis (TB)

5. Discuss any serious medical problems that the patient has had:____
6. List all prescription / over the counter or herbal supplement drugs that the patient is currently taking:

______________________________________, ______________________________________, ____________________________

Adolescent Women:

- ☐ Are you taking oral contraceptive?
- ☐ Are you pregnant now or think you may?
- ☐ Are you nursing?

Allergies *(Please check at least one (1) of the boxes)*

- ☐ Latex
- ☐ Metal
- ☐ Nickel
- ☐ Plastic
- ☐ None
- ☐ Penicillin
- ☐ Food:________________________
- ☐ Nuts: ________________________
- ☐ Other: ________________________

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I hereby authorize the Dentists and staff at Children's Dental FunZone to perform diagnostic aids including X-rays, models and photographs as appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the use of this signature on all insurance submissions. I authorize the dentists 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 my insurance. I understand that I will be charged 24% APR for any past due balances over 60 days. I consent Children's Dental FunZone the using my cell phone number to call or and text regarding appointments, insurance, and my account. I understand that I can withdraw my consent at any time.________(Initial)

Name of parent/legal guardian (please print)	Signature	Date
Review Medical History / Comments	Dentist Signature	Date