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: ______________________________
HOME ADDRESS

____
CITY STATE ZIP

Referred By: ______________________________
(If doctor, please give address & 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: ______________________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

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: ______________________________

3 Child's Family Information

Who is accompanying this child today?

______________________________ ______________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

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

Please Continue On Back

Child's 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(s): ______________

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: ______________ (______) ______________

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? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

Child's Medical History

Is Child taking any of the following medications? ☐ Pain killers (INCLUDING ASPIRIN) ☐ Ritalin ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: ______________

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

______________ Last Medical Exam: ____ / ____ / ____
ADDRESS CITY STATE ZIP

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

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or 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 child wear contact lenses? ☐ Yes ☐ No

Has this 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 ______________ ☐ Parent or Guardian Date ____ / ____ / ____ ☐ Other:

UPDATE
(OFFICE USE)

Initials	Date	Comments
______	__ / __ / __	
______	__ / __ / __	
______	__ / __ / __	

First Impression Forms, Inc. 1-800-99FORMS FORM # 1DGC2 Copyright © 2014