Thank you for choosing our practice for your child's dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Please print all information.

Patient Information

Full name of patient ______________________________

Preferred name ______________________ ❍ Female ❍ Male Birthdate ______________

Child lives with ❍ Both Parents ❍ Mother ❍ Father ❍ Other ______________

What is the reason for today's visit? ______________________________

____

Who referred you to our office? ______________________________

Parent/Guardian Information

MOTHER (full name) ______________________ Birthdate ______________

Relationship to child ❍ Mother ❍ Stepmother ❍ Legal Guardian ❍ Other ______________

Address ______________ City ______________ State ______ Zip ______

Phone numbers: Home ______________ Cell ______________ Work ______________

Email ______________ Name of employer ______________

Social Sec. # or Driver Lic. # ______________________________

FATHER (full name) ______________________ Birthdate ______________

Relationship to child ❍ Father ❍ Stepfather ❍ Legal Guardian ❍ Other ______________

Address ______________ City ______________ State ______ Zip ______

Phone numbers: Home ______________ Cell ______________ Work ______________

Email ______________ Name of employer ______________

Social Sec. # or Driver Lic. # ______________________________

Primary Dental Insurance

Insurance Co. ______________

Address ______________

____

Phone ______________

Group # ______________

Insured Name ______________

Insured ID # ______________

Insured Birthdate ______________

Employer ______________

Secondary Dental Insurance

Insurance Co. ______________

Address ______________

____

Phone ______________

Group # ______________

Insured Name ______________

Insured ID # ______________

Insured Birthdate ______________

Employer ______________

Please continue on the back

Tell us about your child's dental history

Is this your child's first dental visit? ❍ yes ❍ no If no, date of last dental visit ______

Previous Dentist ______

How do you think your child will behave today? (check all that apply)

❍ friendly ❍ happy ❍ anxious ❍ timid ❍ afraid ❍ resistant ❍ combative

Has your child ever had a serious/difficult problem associated with previous dental work? ❍ yes ❍ no

Is your child's water fluoridated? ❍ yes ❍ no Taking fluoride supplements? ❍ yes ❍ no

Does your child brush daily? ❍ yes ❍ no Does your child floss daily? ❍ yes ❍ no

Has your child ever had pain/tenderness in the jaw joint? (TMJ/TMD)? ❍ yes ❍ no

Are you happy with the appearance of your child's teeth? ❍ yes ❍ no If no, explain: ______

Does your child have any of the following habits? (check all that apply)

❍ lip sucking/biting ❍ nail biting ❍ nursing/bottle habits ❍ thumb/finger sucking

Tell us about your child's medical history

Has your child had a history or difficulty with any of the following? If yes to any, please describe.

❍ Anemia or Blood Disease
❍ Asthma
❍ Bleeding Disorder
❍ Brain Injury
❍ Cancer or Malignancies
❍ Cerebral Palsy
❍ Cough, persistent/blood
❍ Diabetes
❍ Eye/Ear/Nose/Throat
❍ Epilepsy/Convulsions
❍ Gag Reflex
❍ Handicap/Disability
❍ Headaches
❍ Hearing Impairment
❍ Heart, Congenital Defect
❍ Heart Murmur
❍ Heart, Other Ailment
Describe:
❍ Hemophilia
❍ Hepatitis
❍ HIV/AIDS
❍ Kidney/Liver Disease
❍ Mental or Learning Delay
❍ Premature Birth
❍ Respiratory Disease
❍ Rheumatic Fever
❍ Scarlet Fever
❍ Speech Disorder
❍ Tonsillitis
❍ Tuberculosis (TB)
❍ Tumors or Growths
❍ Other, explain below

If heart condition present, does your child require an antibiotic premed prior to certain procedures? ❍ yes ❍ no

Name of child's physician ______ Phone ______

Is your child currently under a doctor's care? ❍ yes ❍ no If yes, reason: ______

List all medications your child is currently taking: ______

List all medications your child is allergic to: ______

Has your child had any serious medical problems? ❍ yes ❍ no Describe: ______

Has your child ever been hospitalized and/or had operations? ❍ yes ❍ no If yes, reason: ______

Please provide details for issues checked above: ______

______

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that a change in health or medications can affect dental treatment, and I agree to inform the dentist of any changes for myself, or my minor child, at future appointments.

I certify that I, and/or my dependent(s), have coverage with the insurance company/ies named on the first page of this form, and I assign directly to Westways Dental insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on insurance submissions. I authorize the use and disclosure of health care information to the named insurance company/ies and their agents for the purpose of determining benefits and obtaining payment. I acknowledge that I am financially responsible for all charges, including amounts not paid by insurance.

I grant permission to Westways Dental and its assignees to contact me as needed regarding my account, appointments, or treatment, by methods including phone, text message, and email; messages may be left on my answering machine or with a family member.

______ ______
Signature of Parent/Guardian Date

______ ______
Print name of person signing above Relationship to patient