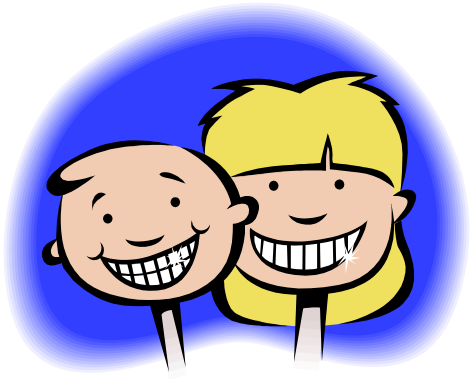

Welcome!

Thank you for selecting our dental healthcare team for your Child!

We will strive to provide your child with the best possible dental care.
To help meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (Confidential)

*Patient #*_____
*Date*_____

Name _____ *Preferred Name* _____
Address _____ *City*_____ *State* _____ *Zip* _____
*Soc. Sec. #*_____ *Birth date* _____ *Age* _____ *Grade* _____
Name of School _____ *City*_____ *County* _____ *State* _____

Parent or Responsible Guardian (Must Sign Form)

Name _____ *Relationship to Patient* _____
Address _____ *City*_____ *State* _____ *Zip* _____
Home Phone # _____ ***Cell Phone #*** _____ ***Can we Text you?*** ☐ **Yes** ☐ **No**
E-Mail _____ ***Can we e-mail you?*** ☐ **Yes** ☐ **No**
*Soc. Sec. #*_____ *Birth date* _____ *Driver's License #* _____
Employer _____ *Work Phone* _____
Spouse or Parent's Name _____ *Employer* _____ *Work Phone* _____
What is the best way to reach you? ☐ *Phone* ☐ *Text* ☐ *Mail* ☐ *E-Mail* ☐ *Other* _____
May we leave a message for you on your answering machine/ voice mail/Text? ☐ *Yes* ☐ *No*
Whom May We Thank For Referring You? _____
*Person to Contact in Case of Emergency*_____ *Phone* _____
********Is any member of the child's immediate family a patient in our office?*** ☐ ***Yes*** ☐ ***No*** **********
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ *Cash* ☐ *Personal Check* ☐ *Credit Card -Visa, MasterCard, Discover* ☐ *I wish to discuss the office's payment policy*

Insurance Information (Please Present Card to be Copied)

Name of Insured _____ *Relationship to Patient* _____
Birth date _____ *Social Security #* _____ *Date Employed* _____
Name of Employer _____ *Union or Local #* _____ *Work Phone* _____
Insurance Company _____ *Have Benefits Been Used this Year?* ☐ *Yes* ☐ *No*
Do you have additional insurance? ☐ ***Yes*** ☐ ***No*** ***If Yes, Complete the following:***
Name of Insured _____ *Relationship to Patient* _____ *Birth date* _____
Social Security # _____ *Date Employed* _____
Name of Employer _____ *Union or Local #* _____ *Work Phone* _____
Insurance Company _____ Have Benefits Been Used this Year? ☐ Yes ☐ No

Over Please

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
Is your child under medical treatment now?	☐	☐
Has your child ever been hospitalized?	☐	☐
Had any surgery or serious illness?	☐	☐
If yes, please explain _____		
_____		
Received General Anesthesia?	☐	☐
Taking any medication(s)?	☐	☐
If yes, what? _____		
_____		
_____		
Is your child allergic to anything food/drug?		
_____		
_____		
_____		
Does your child participate in sports?	☐	☐
If so what sports? _____		
Mouth Protection worn?	☐	☐
Use tobacco?	☐	☐
If Yes, what Form _____		
How Long _____		
Use controlled substances?	☐	☐
Wear contact lenses?	☐	☐
Older Girls Only:		
Are you pregnant/think you may be?	☐	☐

Has this child ever been diagnosed with any of the following conditions?	Yes	No
Anemia	☐	☐
Allergy	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Autism	☐	☐
Cancer If yes: Type _____	☐	☐
Cerebral Palsy	☐	☐
Chicken Pox	☐	☐
Diabetes	☐	☐
Diphtheria/ Tetanus	☐	☐
Emotional Disturbances	☐	☐
Epilepsy/ Convulsions	☐	☐
Excessive Bleeding/ Hemophilia	☐	☐
Fainting	☐	☐
Hearing Loss	☐	☐
Infective Endocarditis	☐	☐
Hepatitis – Type _____	☐	☐
HIV/AIDS infection	☐	☐
Measles/Mumps	☐	☐
Mental Retardation	☐	☐
Nutritional Deficiency	☐	☐

	Yes	No
Orthopedic Problems	☐	☐
Pneumonia	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Scoliosis	☐	☐
Spina Bifida	☐	☐
Other _____		
Organs and Systems:		
Has your child ever been treated for any of the following?	☐	☐
Blood- Circulatory	☐	☐
Bones	☐	☐
Endocrine Glands	☐	☐
Eyes, Ears, Nose, Throat	☐	☐
Gastrointestinal (Stomach)	☐	☐
Kidney - Bladder	☐	☐
Heart	☐	☐
Liver	☐	☐
Muscles	☐	☐
Nervous System	☐	☐
Skin	☐	☐
Tonsils/Adenoids	☐	☐
Other or Explain any yes answers: _____		
_____		

Patient Dental History

Has your child ever been seen by a dentist before Yes ☐ No ☐
Name of Previous Dentist and Location_____ Date of Last Exam _____
Does your child suck his/her thumb or fingers? Yes ☐ No ☐
Are your child's teeth brushed once a day? Yes ☐ No ☐
What type of toothpaste does your child use? _____
Has your child Ever Received Fluoride Before? Yes ☐ No ☐ If yes, what form _____
At what age did your child Stop bottle/breast feeding? _____ Do you have well or city water? _____

Consent for Examination and Treatment

I authorize Dr. Honeycutt or an Associate Doctor and/or his staff to examine and treat my child.
Examination may include Dental Films and Photographs.
Treatment may include but is not limited to cleaning of teeth, application of fluoride, application of sealants, filling of diseased, decayed, or injured teeth, removal (extraction) of teeth, replacement of missing teeth with dental prosthesis, treatment of diseased or injured oral tissues (hard and/or soft), Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities, etc.
Please understand that some physical restraint and voice control may be necessary to avoid injury to your child and/or the staff and to allow communication to take place. We want your child to have a good dental experience and appreciate your assistance in achieving this goal, in many cases this is best achieved by the parent remaining in the waiting area so the Dr. can have the child's undivided attention.
I understand that this consent will remain in effect until such time that I choose to terminate it in writing.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I agree to notify the office of any changes to my child's health or patient information. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I default on this agreement I agree to be responsible for all finance charges and/or collections and attorney expenses incurred. I am aware of the privacy practices and a Notice of Privacy Practices is available to me.

X

Signature of Parent or Legal Guardian *Date Signed*

*UpdatesComments:*_____
_____