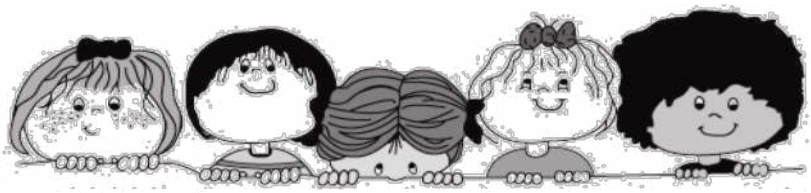
E-Mail: _____



CHILDREN'S DENTAL HEALTH CENTER

Welcome to Children's Dental Health Center. We are pleased to have you and your family join our practice.
Please take a few minutes to fill out this patient information form as completely as you can.
If you have any questions, one of our staff will be happy to assist you.
We look forward to working with you and helping to maintain your child's smile!

Date_____ Child's SS#_____ Child's Medical ID#_____ Birth Date_____

Name of Patient_____ Male __ Female __ Age_____
Last Name First Name M.I.

Home Address_____
Street City State Zip Code

Mailing Address_____
Street City State Zip Code

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____

How did you hear about our office?_____

Parent/Guardian's Name_____ Address_____
(If different from above)

SS#_____ Birth date_____

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____
(If different from above) (If different from above) (If different from above)

Do you have dental insurance/coverage for your minor/child? _____
Is your child eligible for treatment under SoonerCare Insurance? _____

Guarantor's Name_____ Address_____

Employer_____ SS#_____ Birth Date_____

Plan Name_____ Address_____

Phone Number(___)_____ Group #_____ Policy #_____

I will be paying today by cash_____ **check**_____**credit card**_____
Who is responsible for this bill?_____

In the event of an emergency, whom should we contact? Please provide more than one phone number per emergency contact.

Name_____ Relationship_____ Phone(___)_____ Phone(___)_____

Name_____ Relationship_____ Phone(___)_____ Phone(___)_____

Name_____ Relationship_____ Phone(___)_____ Phone(___)_____

Please Complete Both Sides

Has your child had any history of or difficulty with any of the following? ❑ NONE or If yes, please check.

❑ A.I.D.S. / H.I.V.	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney Disease	❑ Rheumatic Fever
❑ Anemia	❑ Chicken Pox	❑ Fainting	❑ Liver Disease	❑ Sinus Problems
❑ Asthma	❑ Convulsions	❑ Hearing Problems	❑ Measles	❑ Thyroid Disease
❑ Autism	❑ Diabetes	❑ Heart Problems	❑ Mononucleosis	❑ Tuberculosis
❑ Cancer	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other _____

Minor/Child's Physician_____ Phone(____)_____

Medications_____

_____

_____

_____

_____

Allergies_____

_____

_____

_____

_____

_____ _____

Signature of Dentist Date

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of_____
(Please Print Name of Minor/Child)
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by health insurance with_____and assign directly to Children's Dental Health Center all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Children's Dental Health Center may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____ _____

Signature of Parent/Guardian or Personal Representative Date

_____ _____

Please print name of Parent/Guardian or Personal Representative Relationship to Patient

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since the last dental appointment? Y/N
If yes, please describe_____

Is patient taking any new medications? Y/N If yes, please list_____

Date _____ Parent/Guardian Signature_____

Has your child had any history of or difficulty with any of the following? ❑ **NONE or If yes, please check.**

❑ A.I.D.S. / H.I.V	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney Disease	❑ Rheumatic Fever
❑ Anemia	❑ Chicken Pox	❑ Fainting	❑ Liver Disease	❑ Sinus Problems
❑ Asthma	❑ Convulsions	❑ Hearing Problems	❑ Measles	❑ Thyroid Disease
❑ Autism	❑ Diabetes	❑ Heart Problems	❑ Mononucleosis	❑ Tuberculosis
❑ Cancer	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other _____

Minor/Child's Physician_____ Phone ( )_____

Medications_____

Allergies_____

_____ _____

Signature of Dentist Date

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