BEAR TOOTH DENTAL

•WELCOME•

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions about this form, please ask and we will be happy to help.

Child Information (Confidential)

Child's Last Name_____ First Name_____ M.I.____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone(_____)_____ DOB_____/_____/_____ Sex M F

Person to contact in case of emergency_____ Phone Number(____)_____

Which payment method do you prefer? Cash_____ Check_____ Visa/MasterCard_____

How did you hear about our office?_____

Parent/Guardian Information

Father_____ Stepfather_____ Guardian_____

Last Name_____ First Name_____ M.I.____

Address (If Different)_____ City_____ State_____ Zip_____

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

SSN_____-_____-_____ DOB_____/_____/_____ Employer_____

Mother_____ Stepmother_____ Guardian_____

Last Name_____ First Name_____ M.I.____

Address (If Different)_____ City_____ State_____ Zip_____

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

SSN_____-_____-_____ DOB_____/_____/_____ Employer_____

Primary Insurance Information

Name of Insured_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

Does the child have secondary insurance? Yes_____ No_____

2nd Insured's Name_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

Child Dental History

Reason for today's visit_____Previous Dentist_____

Is this your child's first visit to the dentist: Yes_____ No_____ If no, date of last dental x-rays/visit_____/_____

Please share with us any concerns you may have with regards to your child's teeth:_____

_____

Please circle below if your child has or has had any of the following problems or habits:

Cavities	Toothache	Bad Breath	Loose Teeth
Crooked Teeth	Sensitive to sweets	Bleeding gums	Teeth Bumped
Sensitive to hot or cold	Frequent headaches	Discolored teeth	Thumb Sucking
Pacifier Use	Teeth Grinding	Other_____	

Child Medical History

Physician_____ **Date of Last Exam**_____/_____

1. Is the child under medical treatment now? Yes_____ No_____
   If yes, please explain_____
2. Has the child ever been hospitalized for any surgical operation or serious illness within the last 2 years? Yes_____ No_____
   If yes, please explain_____
3. Is the child currently taking any medication(s) including non-prescription medicine? Yes_____ No_____
   If yes, please explain_____
4. Is the child allergic to or has the child had any reactions to the following?

Local Anesthetics (ex. Lidocaine)	Yes____	No____
Penicillin or any other antibiotics	Yes____	No____
Sulfa Drugs	Yes____	No____
Barbiturates	Yes____	No____
Sedatives	Yes____	No____
Iodine	Yes____	No____
Aspirin	Yes____	No____
Any Metals (ex. Nickel, mercury etc.)	Yes____	No____
Latex Rubber	Yes____	No____

Other_____

5. Is the child taking any blood thinners? Yes____ No____
6. Is the child in good general health? Yes_____ No_____
   If no, please describe_____
   _____
7. How does your child tolerate dental care?_____
   _____

Please circle if the child currently has or has had any of the following:

ANEMIA	DIABETES	HEPATITS	RADIATION THERAPY
ANGINA	DIZZINESS	HIGH/LOW BLOOD PRESSURE	RECENT WEIGHT LOSS
ARTHRITIS	EPILEPSY/CONVULSIONS	JOINT REPLACEMENT/IMPLANT	RESPIRATORY PROBLEMS
ASTHMA	EMPHYSEMA	KIDNEY DISEASE	RHEUMATIC FEVER
AUTOIMMUNE DISEASE	EXCESSIVE BLEEDING	LIVER DISEASE	SINUS PROBLEMS
AIDS/HIV INFECTION	FAINTING/SEIZURES	LEUKEMIA	STOMACH PROBLEMS/ULCER
BLOOD DISEASE	HEAD INJURIES	MENTAL DISORDER	STROKE
CANCER	HEART DISEASE/ATTACK	MITRAL VALVE PROLAPSE	THYROID PROBLEMS
CHEMOTHERAPY	HEART MURMUR	NERVOUS DISORDER	TUBERCULOSIS
			OTHER_____

Authorization & Release/Consent for Treatment

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 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 insurance benefits otherwise payable to me.

a. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
b. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
c. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Parent/Guardian Signature_____ Date_____/_____/_____