

Welcome

Today's Date ____ / ____ / ____

to the COLUMBIA CENTER FOR DENTISTRY.
Your child's comfort and health are our top
priorities. Please fill out this form completely.

CONFIDENTIAL

Child's Information

Child's Name _____ Nickname _____ Sex _____
Birthdate _____ Age _____ Soc. Sec. # _____ School _____ Grade _____
Child's Home Address _____ City, State, Zip _____ Phone _____

Who is responsible for account?

Name _____ Relation to patient _____
Address _____ City, State, Zip _____ Soc. Sec. # _____
Driver's License # _____ Birth date _____ Employer _____

Who is responsible for making appointments?

Name _____ Relation to patient _____
Home phone _____ Work phone _____ Ext. _____ Best time to call _____

Dental Insurance Information

Insured's Name _____ Relation to patient _____ Birthdate _____ Soc. Sec. # _____
Employer _____ Insurance Company _____ Group # _____
Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Mother Stepmother Guardian

Name _____ Birth date _____
Home Phone _____
Work Phone _____ Ext. _____
Employer _____
Occupation _____
Soc. Sec. # _____
Driver's License # _____

Marital Status Single Married Divorced
 Widowed Separated

Father Stepfather Guardian

Name _____ Birth date _____
Home Phone _____
Work Phone _____ Ext. _____
Employer _____
Occupation _____
Soc. Sec. # _____
Driver's License # _____

Marital Status Single Married Divorced
 Widowed Separated

Whom may we thank for referring you? _____ Relation to patient _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option, which you prefer.

Payment in full is required at each appointment. Cash Personal Check Discover
 Visa MasterCard I wish to discuss financing options

FOR OFFICE USE ONLY:

Dental & Health History

This child's overall health as well as any medications, which the child takes, could have a direct relationship with the dental care the child receives. Please answer each of the following questions completely.

How often does this child brush? _____ How often does this child floss? _____
Is this child's water fluoridated? Yes No Does this child take fluoride supplements? Yes No
Does this child: Consume soda/candy..... Yes No
Suck thumb/finger..... Yes No Snack frequently..... Yes No
Grind teeth/clench jaws..... Yes No Mouth breathe..... Yes No
Chew on objects (pencil, fingernail, etc.)..... Yes No Have speech difficulty..... Yes No
Previous Dentist _____ City _____ State _____ Date of last visit _____
Is this child comfortable being by them self?..... Yes No
Has this child had difficulty with previous dental visits? Yes No Explain _____
Child's Physician _____ Phone # _____ Date of last visit _____
Previous Hospitalizations/Surgeries/Serious Illness and dates: _____

Is this child currently taking medications? Yes No (if yes, please list drug name and dosage)

Does this child have a history of allergies or other reactions to any drugs or medications (penicillin, anesthetics, etc.)? Yes No (if yes, please describe) _____

Does this child have a history of allergies to any other substances (latex, environment, etc.)? Yes No (if yes, please describe) _____

Has this child ever had any of the following:
Asthma..... Yes No Handicaps/Disabilities..... Yes No
Cancer..... Yes No Tuberculosis..... Yes No
Hepatitis..... Yes No Diabetes..... Yes No
HIV/AIDS..... Yes No Rheumatic Fever..... Yes No
Hemophilia..... Yes No Congenital Heart Defect..... Yes No
Abnormal Bleeding..... Yes No Heart
Murmur..... Yes No
Stomach, liver or kidney problems..... Yes No Convulsions/Epilepsy..... Yes No
Please explain any medical problems that this child has: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to this child's health. It is my responsibility to inform the dental office of any changes in this child's medical status. I authorize Columbia Center For Dentistry to perform the necessary dental services this child may need, whether I am present or not. I authorize the use of photographs, radiographs or other technical information for the unlimited use by Columbia Center For Dentistry.

I authorize Columbia Center For Dentistry to release any information including the diagnosis and the records of treatment or examination of this child to third party payers and/or other health practitioners. I authorize and request the dental insurance company to pay directly to the Columbia Center For Dentistry any benefits otherwise payable to me, or the responsible party. I understand that the insurance carrier may pay less than the actual bill for services, or any estimated portion thereof. I agree to be responsible for payment of all services rendered to this child, my dependents or myself.

Child's Name (please print) _____

Signature of parent or guardian _____ Relation to patient _____ Date _____

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