Palm Family Dental LLC
COSMETIC & RESTORATIVE DENTISTRY

1 **Today's Date:** _____

2 **Referred by:** _____

3 ABOUT PATIENT

Child's First Name _____ Child's Last Name _____ Child's MI _____

Is the child ALLERGIC to any of the following:

☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics

☐ Other: _____

Sex: ☐ Male ☐ Female

Child's Address _____ City _____ Zip _____

Child's Nickname _____ Child's Birthdate _____ Child's School _____

Name: ☐ Mother ☐ Stepmother ☐ Guardian _____ Email Address _____

Contact Number _____ Social Security # _____

Address (☐ check if same as child's) _____ City _____ State _____

Name: ☐ Father ☐ Stepfather ☐ Guardian _____ Email Address _____

Contact Number _____ Social Security # _____

Address (☐ check if same as child's) _____ City _____ State _____

4 ACCOUNT & INSURANCE INFORMATION

Policyholder _____ Relationship to Patient _____ Social Security # _____ DOB _____

Billing Address _____ City _____ State _____ Zip _____

Name of Insurance _____ Insurance ID# _____ Group Number _____

_____ **Please Initial** *I, the person responsible for this account, hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I full comprehend I am the person solely responsible for any balance that is not paid by my insurance company.*

SECONDARY DENTAL INSURANCE (if applicable)

Policyholder _____ Relationship to Patient _____ Social Security # _____ DOB _____

Billing Address _____ City _____ State _____ Zip _____

Name of Insurance _____ Insurance ID# _____ Group Number _____

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5 PATIENT DENTAL INFORMATION

Is your child in pain? ☐ Yes ☐ No How long? _____

Please indicate any for the following issues:

- ☐ Discomfort, clicking or popping jaws
- ☐ Red, swollen or bleeding gums
- ☐ Sensitive tooth, teeth or gums
- ☐ Blisters/Sores in or around the mouth
- ☐ Loose tooth
- ☐ Lost/Broken filling(s)
- ☐ Teeth grinding
- ☐ Ringing in ears
- ☐ Broken/Chipped tooth
- ☐ Stained teeth
- ☐ Locking jaw
- ☐ Bad breath
- ☐ Other_____

Previous Dentist _____ Phone _____

Last Dental Exam _____ Last Dental X-Rays _____ Times a Day Child Brushes _____ Times a Day Child Flosses _____

6 PATIENT MEDICAL HISTORY

Child's Physician _____ Phone _____ Last Medical Exam _____

Address _____ City _____ State _____

Does your child have or ever had any of the following diseases, conditions or procedures?:

- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Artifical heart valves
- ☐ Congenital heart defect
- ☐ Scarlet fever
- ☐ Surgeries/operations
- ☐ Cancer/tumors _____
- ☐ Chemotherapy
- ☐ Jaw problems (TMJ/TMD)
- ☐ Hearing problems
- ☐ Diabetes/hypoglycemia
- ☐ Hemophilia
- ☐ Abnormal bleeding
- ☐ Cleft lip/palate
- ☐ Birth defects
- ☐ High/low blood pressure
- ☐ Hepatitis_____
- ☐ Artificial bones/joints/implants
- ☐ Liver/kidney/organ problems
- ☐ HIV+/AIDS/ARC
- ☐ Tonsillitis
- ☐ Respiratory problems
- ☐ Asthma/difficulty breathing
- ☐ Blood transfusion(s)
- ☐ Leukemia/anemia
- ☐ Tuberculosis TB
- ☐ Psychiatric problems
- ☐ Hyper active/ADD
- ☐ Fainting/seizures/epilepsy
- ☐ Celebral palsy

Does your child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Please list any other medical condition(s) your child has or ever had:

_____

7 PATIENT CONSENT FOR SERVICES

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any change in his/her health, I will inform Dr. Palm and his staff at the next appointment.

I have had full opportunity to read and consider the contents of this form AND the Notice of Privacy practices. I authorize staff to perform any necessary services needed during diagnosis and treatment.

The Palm Family Dental policy requires payment in full for all services rendered at the time of visit, unless arrangements have been made with the office manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be held responsible for all legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I will not hold Palm Family Dental responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

SIGNATURE REQUIRED ☐ Parent or Guardian ☐ Other: **DATE**