WELCOME!

We are pleased to welcome you and your child to **TOOTH FIXER DENTAL.** Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date_____ Soc. Sec.#_____ Birthdate_____

Minor/Child_____ Sex ☐M ☐F Age_____
Last Name First Name Middle Initial

Nickname_____ Hobbies_____ Cell Ph._____

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

School Name_____ School Phone_____

Person financially responsible_____ Home Ph._____ Work Ph._____

Whom may we thank for referring you?_____

INSURANCE

Father's / Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ Work Phone_____
(if different from above) (if different from above)

E-mail_____

Employer_____

Soc. Sec.#_____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____ Phone_____

Address_____

Group#_____ Policy#_____

Mother's / Guardian's Name_____

Address (if different from patient's)_____

Home Phone_____ Work Phone_____
(if different from above) (if different from above)

E-mail_____

Employer_____

Soc. Sec.#_____ Birthdate_____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name_____ Phone_____

Address_____

Group#_____ Policy#_____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D.#_____

DENTAL HISTORY

Date of last visit to a dentist_____ For what service?_____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	YES	NO
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ..... ☐ ☐

(Over Please)

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medications or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

Allergies _____

Has minor/child had any history of or difficulty with any of the following? 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
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ other _____

EMERGENCY CONTACT

In the event of an emergency. whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATIONS

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 ever 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 insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Khaja Mohsinuddin all insurance 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.

The above-named doctor 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 or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT. Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist's Signature _____