PATIENT INFORMATION

Child's Name_____ Sex _____ Age ____ Date of Birth_____
First Middle Last

MEDICAL HISTORY

Child's Physician _____Phone Number _____
Has child ever had a blood transfusion? ☐ Y ☐ N
Females: Is child pregnant? ☐ Y ☐ N Is child taking birth control pills? ☐ Y ☐ N

Circle if your child has had any of the following:

AIDS	Epilepsy	High Blood Pressure	ADD
Asthma	Food Allergies	Kidney Problems	ADHD
Lung Disease	Fainting	Latex Allergy	Autism Spectrum Disorder
Cancer	Headaches	Premature Birth	Asperger's
Cerebral Palsy	Heart Surgery	Radiation Treatment	Sensory Deficit Disorder
Diabetes	Heart Murmur	Rheumatic Fever	Psychiatric/Behavioral Problems
Ear Infections	Heart Problems	Spina Bifida	Genetic Disorder
Hearing Problems	Herpes	Thyroid Problems	Bleeding Disorder
Excessive Bleeding	Hepatitis	Venereal Disease	Liver Disease

Is your child currently taking any medications?
If yes, list all:
_____
_____

Does your child have any drug allergies?
If yes, list all:
_____
_____

Does your child have any developmental disorders or syndromes? If yes, list all:
_____
_____

Are there any other outstanding medical problems?
If yes, list all:
_____
_____

DENTAL HISTORY

When was your child's last dental visit?_____ Purpose of today's visit? _____
Name of previous dentist? _____ How many children are in your family?_____
Have there been any injuries to the teeth (blows, falls, etc.) If yes, please describe _____
_____

PRIMARY INSURANCE

Policy holder: _____ Date of birth: _____ Relationship to patient: _____
Policy holder's employer: _____
Insurance Company: _____ Insurance phone #: _____
Contract ID #: _____ Group #: _____

SECONDARY INSURANCE

Policy holder: _____ Date of birth: _____ Relationship to patient: _____
Policy holder's employer: _____
Insurance Company: _____ Insurance phone #: _____
Contract ID #: _____ Group #: _____

Please complete both sides

Father's Name_____ Dad □ Step dad □ **SSN**_____
First Middle Last
Date of Birth_____ Cell Phone #_____ Home Phone # _____
Address _____ City _____ State_____ Zip code _____
Employed by _____ Position _____ Business Phone # _____Ext._____
Email address_____

Mother's Name_____ Mom □ Step mom □ **SSN**_____
First Middle Last
Date of Birth_____ Cell Phone #_____ Home Phone # _____
Address _____ City _____ State_____ Zip code _____
Employed by _____ Position _____ Business Phone # _____Ext._____
Email address _____
Parents Marital Status: □ Married □ Single □ Divorced □ Widowed

If not previously listed, please fill out the following applicable information: □ Stepmother OR □ Stepfather

Name_____ **SSN**_____
First Middle Last
Date of Birth_____ Cell Phone #_____ Home Phone # _____
Address _____ City _____ State_____ Zip code _____
Employed by _____ Position _____ Business Phone # _____Ext._____
Email address _____

Emergency Contact (Friend or Relative)

_____
Name Relationship Home Phone Cell Phone

PAYMENT TERMS

We are pleased if you have dental insurance and we will accept assignment under the following conditions:
1. Coverage/eligibility can be verified. 2. Deductible and percentage not covered by insurance must be paid at time of service.

It is our office policy to expect payment from your insurance carrier within 45 days of billing date. If payment is not received within this time frame, you are responsible for payment in full. We are notifying you of this in advance to prevent any misunderstanding if insurance payment is not received within 45 days.

If you do not have dental insurance, payment is due in full at the time of treatment.

PLEASE NOTE: WE DO NOT FILE ANY INSURANCE FOR ACCIDENTS. PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

AUTHORIZATION

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance. In the event parent/guardian does not pay as herein agreed, the undersigned agrees to pay all cost of collection including a reasonable attorney's fee.

Since _____ is a minor, I hereby grant permission for Dr. Whitney O. Shelton and staff to provide dental treatment for him/her.

Date _____ Signature_____ Relationship _____