WINTERHOLLER DENTISTRY

IMPLANTS | COSMETIC | TMJ | ORTHODONTICS

Child Patient Information

Child's Name: ____ Date: ___________________

Birthdate: ________________________ Age: ______ Social Security Number: ___________________

Sex: ☐ Male ☐ Female

School: ____ Grade: _________________

Parent's Name: ______________________________ Social Security Number: ___________________

Address: ____

City: ____________________________ State: ___________________ Zip: ____________________

Home Phone: _________________ Work Phone: _________________ Cell: ____________________

Employer: ________________________________ Occupation: ______________________________

Parent's Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Dental Insurance

☐ Check box if information is same as above.

Policy Holder Name: ____ Relationship: ____________

Birthdate: _____________________ Social Security Number: _______________________________

Employer: ___________________________ Date Employed: __________ Occupation: __________

Insurance Company: _______________________________ Group Number: ___________________

Employee Number: ____

Authorization and Release

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 payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

Signature of patient or parent if minor: ____ Date: ______________________

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Habits

How often does your child brush? ________________ How often does your child floss?________________

Does your child:

Suck thumb/Finger ☐ Yes ☐ No — Date of last Dental visit: ____________________________

Suck/ Bite lips ☐ Yes ☐ No — Previous Dentist: ________________________________

Bite / Chew nails ☐ Yes ☐ No — Child's Physician: ________________________________

Grind Teeth ☐ Yes ☐ No — Phone #: ____

Clench Jaw ☐ Yes ☐ No — Is your water Fluoridated? ☐ Yes ☐ No

Does Your Child take fluoride supplements? ____

Health History

Has your child had difficulty with previous dental visits? ____

Has your child ever had any of the following:

☐ Asthma	☐ Handicaps/Disabilities	☐ Cancer
☐ Tuberculosis	☐ Diabetes	☐ Hepatitis
☐ HIV/AIDS	☐ Rheumatic Fever	☐ Hemophilia
☐ Congenital Heart Defect	☐ Abnormal Bleeding	☐ Heart Murmur
☐ Allergies	☐ Convulsions/ Epilepsy	

Please Explain any medical problems you're your child has:

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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 my child's health. It is my responsibility to inform the dental office of any changes to my child's medical status.

There will be a $92 dollar fee charge for appointments not cancelled 48hrs in advance.

I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian: ______________________________ Date: ________________

Dr. Signature: ____ Date: ________________

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History Update: ______________________________ Date____