EMINENT DENTAL
TREATING YOU LIKE FAMILY SINCE 1985

PATIENT INFORMATION FOR PATIENTS UNDER 14 YEARS OF AGE (CONFIDENTIAL)

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies _____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

Home phone_____Work phone _____

Cell/other phone_____ Email address _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____Birthdate _____Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

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MEDICAL HISTORY

Physician_____ Date of Last Visit _____
Address_____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is your child currently taking any medication? _____

Yes No Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Please describe._____

Yes No Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____
_____

Circle any of the medical conditions below that the patient has had or currently has.

Asthma or Allergies	Diabetes	Abnormal Bleeding	Congenital Heart Defect
Handicaps/Disabilities	HIV/AIDS	Heart Murmur	Hepatitis
Tumor or Cancer	Rheumatic Fever	Stomach, Liver, Kidney Issue	Persistent Cough or
Radiation/Chemotherapy	Hemophilia	Convulsions/Epilepsy	Throat Clearing
Tuberculosis			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Please describe any previous hospitalizations, surgeries, or serious illnesses._____
_____

DENTAL HISTORY

Previous Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

How often does your child brush his/her teeth? _____
How often does your child floss? _____
Yes No Is your child's water fluorinated? _____
Yes No Does your child take fluoride supplements? _____
Yes No Does your child suck his/her thumb or finger?_____
Yes No Does your child suck or bite his/her lip? _____
Yes No Does your child chew hard objects (pencils, etc.)? _____
Yes No Does your child grind his/her teeth?_____
Yes No Does your child grind his/her teeth?_____
Yes No Does your child clench his/her jaws?_____
Yes No Has your child had difficulty with previous dental visits? _____
Yes No Has your child ever taken Fen-Phen/Redux? _____

Authorization and 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 my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my 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: _____Date: _____