



**WELCOME:** The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we care for you.

**ABOUT YOUR CHILD**

Child's Name: \_\_\_\_\_  
 He/She prefers to be called: \_\_\_\_\_  
 Male  Female  Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_



**WHO IS ACCOMPANYING THE CHILD TODAY?**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Do you have legal custody of this child? Yes No  
 Is the child adopted? Yes No  
 Is the child in a foster home? Yes No  
 Whom may we THANK for the referral? \_\_\_\_\_

**PARENT'S INFORMATION**

Circle One: **Mother** **Step-Mother** **Guardian**  
 Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_  
 Circle One: **Father** **Step-Father** **Guardian**  
 Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Name: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 City, Zip: \_\_\_\_\_  
 Relation: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_

**Note: The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.**

**PRIMARY DENTAL INSURANCE**

Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Insurance Co. Phone #: \_\_\_\_\_  
 Group # (Plan, Local, or Policy #) : \_\_\_\_\_  
 Insured 's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Relation to Insured: \_\_\_\_\_



**SECONDARY DENTAL INSURANCE**

Insurance Co. Name: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_  
 Zip: \_\_\_\_\_  
 Insurance Co. Phone #: \_\_\_\_\_  
 Group # (Plan, Local, or Policy #) : \_\_\_\_\_  
 Insured 's Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Relation to Insured: \_\_\_\_\_

**I hereby authorize payment of the dental benefits otherwise payable to me directly to Grant Rickey, D.D.S.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (continued on back)

**MEDICAL HISTORY**

Child's Physician's Name: \_\_\_\_\_

Child's Physician's Phone #: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_



**In the event of an emergency, please list someone we may contact:**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext: \_\_\_\_\_

Home #: \_\_\_\_\_

Please list any prescription or over-the-counter medications that you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had any of the following diseases or medical problems?**

- |     |                    |     |                   |
|-----|--------------------|-----|-------------------|
| Y N | Abnormal Bleeding  | Y N | Hepatitis         |
| Y N | Anemia             | Y N | Herpes            |
| Y N | Asthma             | Y N | Kidney Problems   |
| Y N | Colitis            | Y N | Liver Disease     |
| Y N | Diabetes           | Y N | Seizures          |
| Y N | Emphysema          | Y N | Shingles          |
| Y N | Epilepsy           | Y N | Sinus Problems    |
| Y N | Frequent Headaches | Y N | Stroke            |
| Y N | Heart Surgery      | Y N | Tuberculosis (TB) |

Is your child allergic to any of the following?

- |     |                    |     |              |
|-----|--------------------|-----|--------------|
| Y N | Aspirin            | Y N | Penicillin   |
| Y N | Codeine            | Y N | Tetracycline |
| Y N | Latex              | Y N | Erythromycin |
| Y N | Dental Anesthetics |     |              |



Please list any drugs/materials that you are allergic to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any medical conditions that have not been asked:**

\_\_\_\_\_  
\_\_\_\_\_



**DENTAL HISTORY**

**Y N** Has your child's **medical doctor** (Not Dentist) determined that you have a heart condition that requires you to take antibiotics before dental treatments?



**Y N** Has your child's medical doctor determined that you require an antibiotic for the care of a joint replacement or implant?

If either of the previous two questions were a "Yes" response, please list the recommended prescriptions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Last visit Date: \_\_\_\_\_

Why has your child come to the dentist today?

\_\_\_\_\_  
\_\_\_\_\_

**Y N** Is your child currently in pain?

Please discuss any problems associated with dental work that your child may have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of Parent or Guardian

Date

**Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.**