



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.

TELL US ABOUT YOUR CHILD

NAME: _____

(Please list first, middle, and last name.)

HE/SHE PREFERS TO BE CALLED: _____

CIRCLE ONE: MALE FEMALE AGE: _____

BIRTHDATE: _____

MAILING ADDRESS: _____

CITY: _____ ZIP: _____

HOME PHONE #: _____

SCHOOL: _____ GRADE: _____

WHO IS ACCOMPANYING HIM/HER TODAY?

NAME: _____

RELATION: _____

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? YES NO

IS THE CHILD IN A FOSTER HOME? YES NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

OTHER FAMILY MEMBERS SEEN BY US: _____

PRIMARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE #: _____

NAME OF EMPLOYER (IF COVERAGE IS THROUGH EMPLOYER):

GROUP # (PLAN, LOCAL, OR POLICY#): _____

SUBSCRIBER'S NAME: _____

RELATION: _____

SUBSCRIBER'S BIRTHDAY: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

PARENT'S INFORMATION

MOTHER/STEP-MOTHER/GUARDIAN: _____

DATE OF BIRTH: _____

HOME PHONE#: _____

EMPLOYER: _____

WORK PHONE#: _____ EXT: _____

SOCIAL SECURITY #: _____

FATHER/STEP-FATHER/GUARDIAN: _____

DATE OF BIRTH: _____

HOME PHONE#: _____

EMPLOYER: _____

WORK PHONE#: _____ EXT: _____

SOCIAL SECURITY #: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____

RELATION: _____

SOCIAL SECURITY #: _____

HOME PHONE #: _____

WORK PHONE #: _____ EXT: _____

BILLING ADDRESS: _____

CITY: _____ ZIP: _____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO GRANT RICKEY, DDS. I UNDERSTAND THAT REGARDLESS OF MY CHILD'S INSURANCE COVERAGE AND BILLING ARRANGEMENT, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL MY CHILD'S DENTAL CHARGES.

SIGNATURE: _____

DATE: _____

NOTE: THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

SECONDARY DENTAL INSURANCE

INSURANCE CO. NAME: _____

INSURANCE CO. PHONE #: _____

NAME OF EMPLOYER (IF COVERAGE IS THROUGH EMPLOYER):

GROUP # (PLAN, LOCAL, OR POLICY#): _____

SUBSCRIBER'S NAME: _____

RELATION: _____

SUBSCRIBER'S BIRTHDAY: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

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 Phone #: _____ EXT: _____

Home Phone #: _____

Please list any prescription or over-the-counter medications that your child is currently taking:

Has your child ever had any of the following diseases or medical problems? (circle all that apply):

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

Please list any medical condition about your child that has not been asked:

Please list any medications that your child cannot take:

Is your child allergic to any of the following (circle all that apply):

Aspirin	Penicillin	Latex
Tetracycline	Dental Anesthetics	

Other: _____

DENTAL HISTORY

Your Child's Previous Dentist: _____

Approximate Last Visit Date: _____

Why have you brought your child to the dentist today?

Is your child currently in dental related pain?

YES NO

Please discuss any problems your child has had with dental work:

Has your child had any pain or discomfort in his/her jaw joint?

YES NO

The information that I have given is correct. It will be held in the strictest of confidence and I will inform this office of any changes in my child's medical and dental status. I authorize the dental staff to perform any necessary dental services with my informed consent.

Parent/Guardian Signature: _____

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!

