



Welcome to Children's Dentistry

Child's Name: (full name) _____ Nickname: _____

Sex: M F Date of Birth: _____ Age: _____

Have we seen any children in your family before: _____ Names: _____

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

Medical Information

Is your child under doctor's care now: _____ For what reason: _____

Is your child taking any medications or drugs: _____ What kind: _____

Has your child ever been hospitalized: _____ When: _____ Reason: _____

Has your child had any difficulty with any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Premature Birth	___	___	Bleeding	___	___	Seizures
___	___	Brain Injury	___	___	Cerebral Palsy	___	___	AIDS/HIV
___	___	Heart Defect	___	___	Anemia	___	___	Asthma
___	___	Cancer/Tumors	___	___	Speech Disorder	___	___	Liver
___	___	Bone Disorder	___	___	Hearing Problems	___	___	Diabetes
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Gag Reflex
___	___	Kidney Problems	___	___	Earaches	___	___	Latex Allergy
___	___	Jaw Problems	___	___	Hyper Active ADHD	___	___	Tuberculosis
___	___	Cleft/ Lip Palate	___	___	Respiratory Problems	___	___	Leukemia

Allergies to medications: _____

Does your child have any emotional or behavioral problems: _____

Dental Information

Reason for visit today: _____ Date of last dental visit: _____

How was your child during his/ her last visit: _____

Former Dentist: _____ City, State: _____

Was your child breast or bottle fed: _____ Until what age: _____

Does your child have any mouth habits, such as finger/ thumb sucking: _____

Has your child had any injuries to his teeth or mouth: _____ If so explain: _____

Does your child brush and floss regularly: _____ How often do they brush: _____ Floss: _____

How may we help to make this visit a positive experience for your child: _____

General Information

Father: (full name) _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Marital Status: _____
Social Security #: _____ - _____ - _____ Drivers License #: _____
Email: _____
Home Phone: () _____ Cell: () _____
Employer: _____ Work Phone: () _____

Mother: (full name) _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Marital Status: _____
Social Security #: _____ - _____ - _____ Drivers License #: _____
Email: _____
Home Phone: () _____ Cell: () _____
Employer: _____ Work Phone: () _____

Name of next of kin, neighbor: (in case of emergency) _____
Relationship to child: _____ Phone: () _____

Insurance Information

PRIMARY:

Name of Insurance: _____ Subscriber: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: () _____ Group #: _____
Subscribers ID: _____ Subscribers Employer: _____

SECONDARY:

Name of Insurance: _____ Subscriber: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: () _____ Group #: _____
Subscribers ID: _____ Subscribers Employer: _____

Consent

I hereby authorize Dr. Mark L. Nelson, D.D.S., and or Dr. M. Brandon Jones, D.M.D., to perform all procedures as determined necessary and/or advisable for the examination and diagnosis of the above named patient.

Signature of Responsible Party

Date

Relationship

Financial Policy

The entire balance will be the responsibility of the party signed below. **Payment to this office is expected on the day of service** rendered, unless arrangements are otherwise made with this office. A finance charge of eighteen (18%) percent APR will be assessed to all balances that are outstanding beyond 60 days from the date of service. **The filing of insurance claims is a courtesy provided by our office** depending upon the correct information given by the insured. If collections become necessary, the responsible party agrees to pay any additional fees up to fifty (50%) percent collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.

Arbitration/Mediation Agreement: Any claim or controversy concerning the terms and conditions of this agreement, or breach thereof, shall be settled by Mediation/Arbitration according to the rules of WESTERN ARBITRATION ASSOCIATION. Judgment(s) on the decision achieved through mediation or rendered by the arbitrator(s) can be entered in any court having jurisdiction thereof.

I have read and accept the terms of this agreement.

Signature of Responsible Party

Date

Relationship

*Due to overwhelming requests, we only do composite "white" fillings, unless requested otherwise in advance. If you would like amalgam "silver" fillings, we will be happy to accommodate you. Please let our staff know in advance so we can ensure that your requests are fulfilled.

