Welcome

You may fill this form out on-screen and print if desired

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Today's Date:

YOUR CHILD:

Child's Legal Name: Nickname: ☐ Male ☐ Female

Birth Date: Age: School: Grade:

Child's Home Address:

City: State: Zip: Phone:

☐ MOTHER

☐ STEPMOTHER ☐ GUARDIAN ?

Name:

Phone:

Email:

Cell Phone:

Employer:

Occupation:

☐ FATHER

☐ STEPFATHER ☐ GUARDIAN ?

Name:

Phone:

Email:

Cell Phone:

Employer:

Occupation:

PERSON BRINGING CHILD

Name:

Relationship:

Phone Number:

What Doctor's Office Referred You?:

PARENT'S MARITAL STATUS

☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated

PRIMARY DENTAL INSURANCE

Insured's Name: D.O.B. Social Security #:

Relationship to child: Insured address (if different fromchild):

Employer: Occupation:

Insurance Company: Group #: SSN / ID#:

Insurance Company Address:

COMMENTS

DENTISTRY 4 CHILDREN & TEENS 2

FLEMING ISLAND
1530 Business Center Drive, Suite 1
Orange Park, Florida 32003
Phone: (904) 215-4221
Fax: (904) 215-9887

OAKLEAF TOWN CENTER LOCATION
9640 Crosshill Boulevard, Suite 101
Jacksonville, Florida 32222
(904) 404-4444
Fax: (904) 404-4440

Health History

Has your child ever had any of the following?

- ☐ Asthma
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Speech Impairments
- ☐ Abnormal Bleeding
- ☐ Hearing Loss
- ☐ Previous Surgery ☐ MTHFR mutation_____
- ☐ Behavioral/Learning Problems/Autism/Aspergers Syndrome _____
- ☐ Handicaps/Disabilities
- ☐ Heart Murmur.

Requires Pre-med? ☐ Yes ☐ No What Medication?

- ☐ Congenital Heart Defect.

Requires Pre-med? ☐ Yes ☐ No What Medication?

- ☐ Convulsions/Epilepsy.

Requires Pre-med? ☐ Yes ☐ No What Medication?

Previous Dental Hx

How long since your last dental visit?

Reason for that visit?

Were any x-rays taken at the last visit? ☐ Yes ☐ No

Previous Dentist:

Child's Physician:

Phone Number:

Has your child had difficulty with previous visits? ☐ Yes ☐ No

If yes, explain:

Allergy to medications:

Any Medical problems:

Child currently taking any medications:

How did you hear about us? ☐ Google Ad ☐ Facebook ☐ Internet search ☐ Insurance company ☐ Doctor's Office

☐ Event: ☐ Patient we have seen (who can we thank?):

☐ Other:

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 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 payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise paybale 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 parent or guardian: Date: