

# Little People's Dental

## Patient Information

Patients Name \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Hobbies \_\_\_\_\_

\*Whom may we thank for referring you? \_\_\_\_\_

## Medical History

Child's Physician \_\_\_\_\_ Date of last exam \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Is your child currently under the care of a physician? Y/N (If yes, for what?) \_\_\_\_\_

Is your child currently taking any medications? Y/N (If yes, what?) \_\_\_\_\_

Has your child ever been hospitalized or had surgery? Y/N (If yes, for what and when) \_\_\_\_\_

Does your child have any allergies to medicines, foods, or other materials? Y/N (If yes, what?) \_\_\_\_\_

**Does your child have a history of any of the following: (Please note any significant past medical history not listed here under "other".)**

	*CIRCLE Y/N*		*CIRCLE Y/N*		*CIRCLE Y/N*
Heart trouble or murmurs	Y N	<b>Asthma</b>	Y N	Hepatitis	Y N
Rheumatic Fever	Y N	<b>Kidney Disease</b>	Y N	Anemia	Y N
Seizures/Convulsions	Y N	<b>Diabetes</b>	Y N	Cancer	Y N
Bleeding problems	Y N	<b>AIDS/HIV</b>	Y N	Epilepsy	Y N
Blood Disorders	Y N	<b>Liver Disease</b>	Y N	Deafness	Y N
Premature Birth	Y N	<b>Lung Disease</b>	Y N	Other	Y N

If other, please explain. \_\_\_\_\_

## Dental History

Date of last dental exam \_\_\_\_\_ For what service? \_\_\_\_\_

Previous dentist \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Has your child experienced any unfavorable reaction from previous medical or dental care? Y/N (If yes, please explain) \_\_\_\_\_

How do you think your child will act toward the dentist \_\_\_\_\_

Has your child had any past injury to head, face, or teeth? Y/N (If yes, please explain) \_\_\_\_\_

Has your child complained about a dental problem? Y/N (If yes, what?) \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Is the brushing supervised? Y/N

Do you floss your child's teeth? Y/N

Does your child use fluoride? Y/N (If yes, what kind: **Drops** / **Tablets** / **Paste**)

Do you have any other concerns about your child that we should discuss? Y/N (If yes, please explain.) \_\_\_\_\_

**Authorization, Family Information, & Financial Responsibility**  
**\*\*\*Please fill in completely and Initial (4 places) & Sign at bottom of page\*\*\***

**Responsible Party**

Guarantor Name \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Social Security #** \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home/Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ **Home Phone** \_\_\_\_\_  
**Mom cell#** \_\_\_\_\_ **Dad cell #** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Other Parent Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Sex \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

**Insurance Information** (Please fill in completely and provide a copy of your card.)

Dental insurance name \_\_\_\_\_ Phone # \_\_\_\_\_  
Claims address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Policy Holder's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Social Security #** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

Medical Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Medical Insurance Policy # \_\_\_\_\_  
Do you have Medicaid for your secondary insurance? Y N (If yes, ID# \_\_\_\_\_)

**Emergency Contact Information** (Someone other than immediate family)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**Authorization**

I have answered all of the previous questions to the best of my knowledge and understand the dentist will use this information to determine appropriate dental treatment for my children. I agree to notify the dentist of any changes in my children's health status immediately.\*\*\*INITIALS \_\_\_\_\_

I hereby authorize the Doctors and staff of Little People's Dental to provide dental treatment for my children. I consent to such treatment, medications, and treatment methods as are deemed appropriate by the doctors and staff in providing the safest and best possible dental care for my children.\*\*\*INITIALS \_\_\_\_\_

I hereby authorize Little People's Dental to release all information necessary to secure payment of benefits and authorize my insurance company to pay the benefits otherwise payable to me. I also authorize the use of my signature on all insurance claim submissions.\*\*\*INITIALS \_\_\_\_\_

I understand that I am responsible for payment of all services provided and that the office does insurance as a courtesy. I also understand that I am responsible to pay at time of service 100% of any services deemed by the dentist's office to be non-covered by insurance. I understand this is not a guarantee that the insurance will pay the balance of the services. In the event the insurance does not pay the estimated balance in full, I understand that I will be billed for the difference. I agree to an interest of 1.5% per month (18% per anum) on any unpaid balance. Some insurance companies pay less for white fillings on back teeth. We use only white fillings in our office. Any amount not covered by insurance is your responsibility. I also understand in the event of failure to pay the balance this account will be placed with a collection agency and I agree to pay an additional 50% plus all incurred legal fees to cover these expenses.\*\*\***I understand that a \$50 charge may be made for broken appointments unless the office is notified 48 hours in advance.** \*\*INITIALS: \_\_\_\_\_.

**Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_