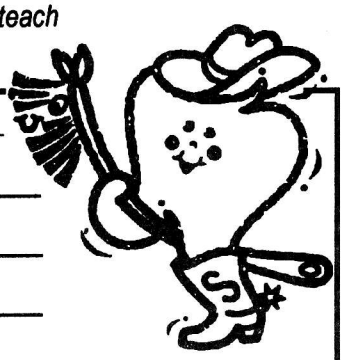
Welcome and thank you for selecting us!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits that will help keep their teeth healthy for their lifetime.



Name Child Goes By_____

Child's Name _____ Age _____ D.O.B. _____

☐ Male ☐ Female Birth Place _____ SS# _____

School _____ Grade _____

Parent's Names _____

Name of Sisters _____ Name of Brothers _____

What activities does your child enjoy? _____

Why are you here today? ☐ Exam ☐ Toothache ☐ Decay ☐ Trauma ☐ Other

Who may we thank for referring you? _____

Child's Physician _____ Phone # _____

Previous Hospitalizations/ surgeries/ serious illnesses / When? _____

Does your child have allergies / sensitivities / adverse reatctions to any medications? _____

If yes, please describe _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes please list) _____

Has your child ever had any of the following?:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Respiratory Infections	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV / AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect/Heart Murmur	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Brain or Nerve Injury	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

How often does your child brush?_____

How often does your child floss?_____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit_____

Previous Dentist_____

Address_____

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

Please explain any medical problems that your child has: _____

Who is Responsible for Making Appointments?

Name _____ Who Does Child Live With? _____

Phone: Home _____ Cell _____ Work _____ Ext. _____

Mother

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Occupation _____ Dept. _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

SS# _____ DL# _____

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Other

Father

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Occupation _____ Dept. _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

SS# _____ DL# _____

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Other

Step Mother/Guardian

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Occupation _____ Dept. _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

SS# _____ DL# _____

Relationship to patient _____

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Other

Step Father/Guardian

Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Occupation _____ Dept. _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

SS# _____ DL# _____

Relationship to patient _____

Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Other

Primary Dental Insurance

Insured's Name _____ DOB _____

Relationship _____

D.O.B. _____ SS# _____

Employer _____

Occupation _____

Insurance Company _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Group # _____ Emp. ID _____

Effective Date _____

Tele./800# _____

Additional Dental Insurance

Insured's Name _____ DOB _____

_____ Relationship _____

D.O.B. _____ SS# _____

Employer _____

Occupation _____

Insurance Company _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Group # _____ Emp. ID _____

Effective Date _____

Tele./800# _____

Financial Arrangements - PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT.

For your convenience, we offer the following methods of payment. Please check the option you prefer.

❒ Cash ❒ Personal Check Credit Card: ❒ VISA ❒ MasterCard ❒ Discover

Authorization and Release *Signature Required *

I have recorded the prior information to the best of my knowledge, and give fully informed consent for treatment & release of records. I authorize direct payment to Dr. Carter by my insurance company. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES, AND I AGREE TO BE RESPONSIBLE FOR ANY BALANCE INCURRED. PAYMENT IS DUE IN FULL AT TIME OF BILLING.

_____

Signature of Patient or Guardian, if minor Date