COTTONWOOD DENTAL

Welcome! We would like to welcome you to our office.

ABOUT YOUR YOUTH

Name _____ Nickname _____ Age _____ Referred By _____

Birthday ____/____/____ Sex _____ Social Security # _____

Home Address _____ Guardian Phone # _____

City _____ State _____ Zip _____ Special Interests _____

ABOUT YOU

Your Name _____ Social Security # _____

Relationship to child _____

Your Address (if different from child) _____

Your Phone _____ Work Phone _____ Other Phone _____

Occupation _____ Employer _____

DENTAL INSURANCE

Dental Ins. Co. _____

Their phone # _____ Group # _____

This dental insurance is provided through:

Employer _____

Insured's Name _____

Insured's Social Security # _____

Insured's Birthday _____

2nd Dental Ins. Co. _____

Their phone # _____ Group # _____

Insured's Social Security # _____

DENTAL / MEDICAL HISTORY

When was your child's last visit? _____

List any dental concerns _____

_____

Please rate your child's oral health: Good ___ Fair ___ Poor ___

Is your child currently under a physicians care? Yes ___ No ___

Reason _____

Child's Physician _____

Please rate your child's medical health: Good ___ Fair ___ Poor ___

Has your child ever had any of the following medical conditions?

Heart Murmur	Yes ___ No ___
Heart Problems of any kind	Yes ___ No ___
Convulsions / Epilepsy	Yes ___ No ___
Cancer	Yes ___ No ___
Diabetes	Yes ___ No ___
Rheumatic Fever	Yes ___ No ___
HIV &/ AIDS	Yes ___ No ___
Hemophilia	Yes ___ No ___
Bleeding problems of any kind	Yes ___ No ___
Hearing Impairment	Yes ___ No ___
Hyperactive	Yes ___ No ___
Any Operations	Yes ___ No ___
Any stays in hospital	Yes ___ No ___
Allergic to any drugs	Yes ___ No ___
Does your child need to be premedicated before treatment	Yes ___ No ___
Are there any other medical conditions or problems relating to your child	Yes ___ No ___

If yes, please explain _____

_____

_____

In event of an emergency, Contact _____

Relationship _____ Phone _____ Phone #2 _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental service my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature _____

AUTHORIZATION AND RELEASE

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 payable 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.