Welcome to Mill Creek Children's Dentistry

We are excited that you have selected us to provide dental care for you and your family.
Please review this print-out, and sign the Consent For Treatment on Page 2.

COMPLETE CHILD INFORMATION

Child's Full Name: Date Submitted:

Nickname: Gender: ☐ **Male** ☐ **Female**

Child's Birthdate: Age:

List of anyone who may accompany the patient and their relationship to the patient:

How did you hear about us?

PARENT OR GUARDIAN INFORMATION

Parent or Guardian's Name: Social Security No.:

Email: Birthdate:

Address:

City: State: Zip:

Home Phone: Mobile Phone:

Employer: Occupation:

Duration of Employment

Marital Status:

Spouse's Name: Spouse Social Security No.:

Spouse Email: Spouse's Birthdate:

Spouse's Home Phone: Spouse's Mobile Phone:

Spouse Employer: Spouse Occupation:

Duration of Employment:

BILLING INFORMATION (IF DIFFERENT THAN PARENT INFORMATION)

Billing Name: Social Security No.:

Billing Address:

Billing City: State: Zip:

Phone: Work Phone:

Employer: Occupation:

Duration of Employment:

NEAREST RELATIVE

Name of nearest relative not living with you?
Phone:

Relationship to the patient?

Patient Name: Date Submitted:

INSURANCE INFORMATION

Policy Owner's Name: Birthdate: SS No.:

Insured's Employer:

Dental Insurance Company: Insurance Phone:

Group Number: Policy #:

Address:

City: State: Zip:

Do you have dual coverage? If no, please skip to the Medical History section. ☐ **Yes** ☐ **No**

Insured's Name: Birthdate: SS No.:

Insured's Employer:

Dental Insurance Company: Insurance Phone:

Group Number: Policy #:

Address:

City: State: Zip:

MEDICAL HISTORY

Patient's primary care physician: Physician's Phone:

How would you describe your child's overall health?

When was the child's last physical?

Has your child been hospitalized for a surgical procedure? ☐ **Yes** ☐ **No**

If so, why?

Has your child been hospitalized for a non-surgical procedure? ☐ **Yes** ☐ **No**

If so, why?

Is your child currently taking any medications? ☐ **Yes** ☐ **No**

If so, please list each medication and the reason it is being taken:

Has your child ever had an adverse reaction or allergies to any medication or substance? (Please check if allergic.) *

☐ **None** ☐ **Foods - List Below** ☐ **Latex** ☐ **Sulfa Drugs** ☐ **Valium**
☐ **Antihistamines** ☐ **Erythromycin** ☐ **Penicillin/Amoxicillin** ☐ **Tetracycline** ☐ **Xylocaine**
☐ **Codeine** ☐ **Iodine**

Others (including food allergies):

Has the patient ever had any of the following? (Please check all that apply) *

☐ **None**
☐ **Heart problems (Murmur etc.)**
☐ **Blood or bleeding disorder**
☐ **Asthma**
☐ **Difficulty Breathing**
☐ **Respiratory Problems**
☐ **High Blood Pressure**
☐ **Low Blood Pressure**
☐ **Artificial Joints/Implants**
☐ **Muscular Problems**
☐ **Bone or Joint Problems**
☐ **Nervous Disorder (Seizure, Epilepsy)**
☐ **Hormone, Kidney or Liver Problem**
☐ **Diabetes/Hypoglycemia**
☐ **Hemophilia/Anemia**
☐ **Leukemia**
☐ **Skin Condition**
☐ **Digestion Problems**
☐ **Cancer**
☐ **Pregnancy**
☐ **Vision or Hearing Problem**
☐ **Surgery (Explain Below)**
☐ **Down Syndrome/Trisomy 21**
☐ **HIV/AIDS or ARC**
☐ **Cleft Lip or Palate**
☐ **Submucosal Cleft Syndrome**
☐ **Tuberculosis (TB)**
☐ **Hepatitis/Jaundice**
☐ **Organ Problems (Explain Below)**
☐ **Other**

Does your child have any condition, health problem or food allergy not listed which we should know about? Please explain:

Patient Name: Date Submitted:

DENTAL HISTORY

Reason for this visit?

Is this your child's first dental visit? ☐ **Yes** ☐ **No**

If no, date of last visit: Date of last x-ray:

Treatment performed:

Name of former dentist:

Phone: Type of dentist:

Was your child breast fed? ☐ **Yes** ☐ **No** ☐ **Currently** If yes, until what age?

Was your child bottle fed? ☐ **Yes** ☐ **No** ☐ **Currently** If yes, until what age?

Has your child ever had any injuries to his or her teeth, mouth, head or jaws? ☐ **Yes** ☐ **No**

If yes, please describe:

Your child drink juice or soda most days? ☐ **Yes** ☐ **No**

Your child eat sweets, crackers or gummies most days? ☐ **Yes** ☐ **No**

Does your child brush daily? ☐ **Yes** ☐ **No**

Does an adult assist with brushing ☐ **Yes** ☐ **No**

Does your child floss? ☐ **Yes** ☐ **No**

Does an adult assist with flossing? ☐ **Yes** ☐ **No**

Does your child have any of the following mouth habits:

☐ **None** ☐ **Mouth Breathing** ☐ **Lip Sucking** ☐ **Pacifier**
☐ **Finger Sucking** ☐ **Teeth Grinding** ☐ **Nail Biting** ☐ **Thumb Sucking**

Other:

Is your familyon well water? ☐ **Yes** ☐ **No**

Other:

Has your child had any bad dental or medical experiences in the past? ☐ **Yes** ☐ **No**

If yes, please explain:

Please check any of the following that may describe your child:

☐ **Anxious** ☐ **Defiant** ☐ **Mellow** ☐ **Shy** ☐ **Suspicious**
☐ **Cooperative** ☐ **Friendly** ☐ **Outgoing** ☐ **Stubborn** ☐ **Trusting**
☐ **Curious** ☐ **Hyper**

Child's interests:

Favorite sport: Favorite movie:

How can we make this a more positive experience for your child?

CONSENT FOR TREATMENT

I am legally authorized to obtain medical/dental services for this patient. To the best of my knowledge, the questions on this form have been accurately answered. I authorize the dental staff to perform the necessary dental services to my child may need. I also authorize the release of information including the diagnosis and records of treatment/examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize amd request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. *There will be a $35.00 charge for all missed appointments and for all appointments cancelled without 48 hours notice. I understand that I am financially responsible for payment of all services rendered on my or my dependents' behalf.

Date:_____ Signature (patient or parent for minor)_____

Preferred method of payment: _____Cash _____Check _____Bankcard