PATIENT INFORMATION

Patients Date of Birth :_____
Patients Name:

First-_____Initial-_____

Last-_____

Nickname: _____

If Child:
Parents Name:_____

[] Single [] Married [] Separated
[] Divorced [] Widowed [] Minor

Home Address:
_____
_____

Home Phone:_____
Cell Phone: _____
Email:_____

Employed By:_____

Work Address:
_____
_____

Work Number:_____

Spouse/Parent Name:_____

Spouse Employed By:_____

Who is Responsible For Account:_____

Other Family in this Practice:
_____
_____

Social Security No.
Patient:_____
Spouse/Parent:_____

Emergency Contact:_____
Number :_____

Dental Insurance FIRST Coverage:

Employee Name:_____
Date of Birth:_____
Relationship to Patient:_____
Employer Name:_____
Name of Insurance company:
_____
Address:
_____
_____
Telephone:_____
Program or Policy #:_____
Social Security No.:_____
Union Local or Group # :_____

Dental Insurance SECOND Coverage:

Employee Name:_____
Date of Birth:_____
Relationship to Patient:_____
Employer Name:_____
Name of Insurance company:
_____
Address:
_____
_____
Telephone:_____
Program or Policy #:_____
Social Security No.:_____
Union Local or Group #:_____

[] No Insurance

How did you hear about us?
[] Family/Friend [] Phone book
[] Newspaper []Internet

Patient or Guardian's Signature
_____

Date:_____

Sandy Valley Dental Care
Joseph C. Wigfield D.D.S ~ (330)866-5555

CHILD DENTAL / MEDICAL HISTORY

Patient's Name: (F)_____(M)____(L)_____ DOB:_____

Parent's/Guardian's Name: _____

DENTAL

Is this your child's first visit to the dentist?.....YES NO … Last dental visit?: _____
Has your child had dental X-Rays taken? ….....YES NO
Has your child had any problem with dental treatment in the past? ….....YES NO
Has your child ever received a local anesthetic? ….....YES NO
Has your child ever had occlusal sealants? ….....YES NO
Does your child eat sweets, chewing gum, drink soda pop?.....YES NO
Have there been any injuries to teeth, such as falls, blows, chips, etc?..... YES NO
Does your child think there is anything wrong with his/her teeth? ….....YES NO
When does your child brush his/her teeth?
[] Upon arising [] After eating any meals [] Before going to bed
How does your child receive Fluoride?
[] Community water [] Well water [] Fluoride drops / tablets [] Fluoride rinse / gel

MEDICAL

Does your child have a health problem? ….....YES NO
Is your child under the care of a physician? ….....YES NO
If Yes, since when / why? _____
Name of physician _____ Phone _____
Is your child receiving any medication? ….....YES NO
What? _____
Is your child allergic to penicillin, antibiotics, or other drugs? ….....YES NO
Is your child allergic to or sensitive to any metals or latex? ….....YES NO
Does your child have allergies? ….....YES NO
Has your child had any serious illnesses? ….....YES NO
When / What? _____
Has your child ever had surgery?.....YES NO ... Is surgery contemplated? ….... YES NO
Does he/she have a heart murmur?.....YES NO
Does your child experience severe or prolongated bleeding? ….....YES NO
Does your child have AIDS or has been tested HIV positive? ….....YES NO
Has your child tested positive for hepatitis? ….....YES NO
Is your child subject to... [] frequent headaches [] fainting [] seizures [] dizziness [] behavioral/ learning problems

Has your child had history of : (Circle appropriate response) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, cancer, eyesight problems, infections, speech impairment, hear loss.

Comments:

_____
_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
PATIENT/ GUARDIAN'S SIGNATURE _____ DATE_____
DENTIST SIGNATURE _____

Patients (child) name: _____ DOB:_____

CONSENT FROM PARENT OR GUARDIAN

I consent to the diagnostic procedures and treatment deemed necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or the records for which I am legal guardian) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or the records for which I am legal guardian) to the following persons. (Please list anyone authorized to discuss your treatment or records e.g. spouse, guardian.)

_____ _____

My consent to disclosure of records shall be effective until I revoke in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, by my dental care payor.

I attest to the accuracy of the information on this consent section.

PATIENT/GUARDIAN'S SIGNATURE _____DATE_____