



**CHILD PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)

Male  Female

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Cod

Parent's E-Mail Address: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ **(MOBILE):** \_\_\_\_\_

**Employment Information**

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

Is your child covered by dental Insurance?  YES  NO, (If Yes, please fill out Dental Insurance Information below.)

**Insurance Information**

**PRIMARY INSURANCE**

Name of Insured Subscriber: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Subscriber ID #: \_\_\_\_\_ Plan Group #: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insured Subscriber: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Subscriber ID #: \_\_\_\_\_ Plan Group #: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_



**MEDICAL AND DENTAL HISTORY**

Is your child in good health?  YES  NO

Has your child ever been hospitalized?  YES  NO Why? \_\_\_\_\_

Has your child had a medical checkup in the last year?  YES  NO

Is your child sensitive to any drugs or foods?  YES  NO  
If so, what drugs or foods? \_\_\_\_\_

Is your child allergic to latex?  YES  NO

Is your child taking any medications?  YES  NO What? \_\_\_\_\_

Has your child had surgery or is any surgery contemplated?  YES  NO  
Operation and dates: \_\_\_\_\_

Is this your child's first visit to a dentist?  YES  NO

Has your child experienced any unfavorable reaction to previous dental care?  YES  NO  
If so, briefly describe: \_\_\_\_\_

Ear/Hearing Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Endocrine Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Autoimmune Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skeletal/Muscle Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Tumors	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye/Vision Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiovascular/Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neurological Problems/Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma/Breathing Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	GI/Stomach/Digestive Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Genetic Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	MRSA Positive	<input type="checkbox"/> YES <input type="checkbox"/> NO
Developmental Delay	<input type="checkbox"/> YES <input type="checkbox"/> NO	Autism/ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO
G-Tube Placement	<input type="checkbox"/> YES <input type="checkbox"/> NO	To Much Saliva/Drooling	<input type="checkbox"/> YES <input type="checkbox"/> NO
Teeth Grinding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cleft Lip/Palate	<input type="checkbox"/> YES <input type="checkbox"/> NO

Any other Special Needs and please describe anything from above:

Please describe your child's diet: (Organic, Gluten Free, juice, sodas, fruits, and vegetables?)

Does your child take liquids at bedtime or at night in a bottle or sippy cup?  YES  NO

Does your child drink Pediasure or similar?  YES  NO

Are you currently breast feeding your child?  YES  NO

Does your child use a pacifier?  YES  NO

Has or does your child suck a thumb or finger(s)?  YES  NO

Are you opposed to fluoride treatments for your child? YES NO

Are you opposed to mercury containing silver fillings for your child? YES NO



## AUTHORIZATION FOR TREATMENT

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my child's health or medication.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon my child and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies some risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice and for the payment to be applied directly to any outstanding balance on my account.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare options, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available in our office and on our website, and we encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You have the right to revoke this consent at any given time by giving us written notice of your revocation submitted to Dr. Cros. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination and treatment plan.

Signature of parent: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_