ABOUT YOUR CHILD

Today's Date:______/_____/_______

Patient Name:____
LAST FIRST MI

Preferred Name:_________________ ( ) Male ( ) Female

Birthdate:_______/______/________ Age:________

Mailing Address:____________________________________

____
CITY STATE ZIP

Preferred

( ) Home Phone #:(______) ______________________

( ) Cell Phone #:(______) ______________________

( ) Work Phone #:(______) ______________________

Parent's E-mail Address:____________________________

Referred by:_______________________________________

INSURANCE INFO

DO YOU HAVE DENTAL INSURANCE? ( ) YES ( ) NO

PRIMARY INSURANCE

Ins. Co Name:_____________________________________

Address:____

____
CITY STATE ZIP

Phone #:(______) ______________________

Insured's Name:____________________________________

Relation:______________ DOB: _______/_______/________

Insured's Employer:_________________________________

Insured's ID#______________________________________

Group # (Plan ID, Local #, Policy#)______________________________

SECONDARY INSURANCE

Ins. Co Name:_____________________________________

Address:____

____
CITY STATE ZIP

Phone #:(______) ______________________

Insured's Name:____________________________________

Relation:______________ DOB: _______/_______/________

Insured's Employer:_________________________________

Insured's ID#______________________________________

CHILD'S FAMILY INFORMATION

Who is accompanying your child today?

__________________________________ __________________
FULL NAME (IF OTHER THAN PARENT) RELATION

Do you have legal custody of this childs? ( ) Yes ( ) No

Mother's Name:__________________________________
LAST FIRST MI

Address: ( ) Same as child's

____

____
CITY STATE ZIP

______/____/______ ____/____/_____ _________________
SOCIAL SECURITY # DATE OF BIRTH DRIVER'S LIC #

(______) _______________(______) __________________
CELL PHONE WORK PHONE

Employer:____

Father's Name:__________________________________
LAST FIRST MI

Address: ( ) Same as child's

____

____
CITY STATE ZIP

______/____/______ ____/____/_____ _________________
SOCIAL SECURITY # DATE OF BIRTH DRIVER'S LIC #

(______) _______________(______) __________________
CELL PHONE WORK PHONE

Employer:____

ACCOUNT INFORMATION

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT:

( ) MOTHER ( ) FATHER

Payment Method: ( )Cash ( )Check ( )Credit Card

________ I hereby authorize assignment of my insurance rights and benefits to Arlington Dental Solutions, office of Dr. Tamara Garrett. I fully understand I am solely responsible for any balance not paid by my insurance company.

CHILD'S DENTAL INFORMATION

Reason for today's visit: ( ) Exam/Consultation ( ) Emergency Is the child in pain: ( ) No ( ) Yes How long:___________

Please indicate any of the following problems:

( ) Clicking, pain, or popping in jaw ( ) Sensitive teeth ( ) Red, swollen, or bleeding gums ( ) Lost or broken fillings
( ) Ringing in ears ( ) Frequent headaches ( ) Teeth Grinding ( ) Blisters/sores in or around mouth
( ) Bad Breath ( ) Broken or chipped teeth ( ) Stained Teeth ( ) Unhappy with appearance of teeth or smile

Previous dentist name:____ Phone # (_____) __________________

MEDICAL HISTORY

Physician Name:____ Phone # (_____) __________________

Does your child require antibiotic pre-medication? ( ) Yes ( ) No ( ) I don't know

Does your child require a change in your medication before dental treatment? (ie:blood thinners, diuretics) ( ) Yes ( ) No

Does your child take any medications? ( ) NONE or ( ) See list below

( ) Nerve Pills ( ) Pain medication ( ) Blood Thinners ( ) Aspirin ( ) Muscle Relaxers

( ) Stimulants ( ) Insulin ( ) Osteoporosis Meds ( ) Tranquilizers

____

____

____

Does your child have any medical conditions we should be aware of? ( ) NONE or ( ) See list below

____

____

____

Has your child EVER taken the following: ( ) Biosphosphates ie: Aredia/Fosamax ( ) Phen-fen/Redux

Does your child have or has your child ever had any of the following:

( ) Heart Attack	( ) Kidney Problems	( ) HIV/AIDS/ARC	( ) X-ray Treatment	( ) Glaucoma
( ) Stroke	( ) Liver Problems	( ) Arthritis	( ) Chemotherapy	( ) Hepatitis______
( ) Heart Murmur	( ) Sinus Problems	( ) Psychiatric Problems	( ) Asthma	( ) Nervousness
( ) MVP	( ) Sinus Problems	( ) Rheumatism	( ) Difficulty Breathing	( ) Anemia
( ) Rheumatic Fever	( ) Venereal Disease	( ) Artificial Bones	( ) Diabetes	( ) Fainting
( ) Artificial Valves	( ) Artificial Joints	( ) Alcohol Abuse	( ) Hypoglycemia	( ) Shingles
( ) Heart Disease	( ) Drug Abuse	( ) Emphysema	( ) Leukemia	( ) Neck Pain
( ) Heart Defect	( ) Tuberculosis	( ) Chest Pains	( ) Jaw Problems/TMJ	( ) Frequent Headaches
( ) High Blood Pressure	( ) Low Blood Pressure	( ) Scarlet Fever	( ) Cancer/Tumors	( ) Back Problems
( ) Bleeding Problems	( ) Thyroid Problems	( ) Cosmetic Surgery		

Is your child allergic to any of the following? ( ) Latex ( ) Penicillin/Amoxicillin ( ) Tetracycline ( ) Aspirin
( ) Dental Anesthetic ( ) Sulfa ( ) Foods:__________________________ ( ) Other: _______________________________________

Rate your child's general health from 1-10:_________

Does your child do any of the following? ( ) Thumb/finger sucking ( ) Tongue thrusting ( ) Heavy snoring
( ) Mouth Breathing ( ) Lip sucking/biting ( ) Fingernail biting

I understand the above information and guarantee this firm was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE:____ DATE:________/________/_________