

Today's Date _____

Welcome to our Practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits, which will help, keep their smile beautiful for their lifetime.

Your Child

Child's Name _____

Nickname _____ Sex _____

E-mail _____

Birthdate _____ Age _____

Social Security No. _____

School _____ Grade _____

Child's home address _____

City, State, Zip _____

Phone _____

Mother Stepmother Guardian
Name _____

Cell Phone _____

Home Phone _____

Work Phone _____

Social Security No. _____

Employer _____

Occupation _____

Father Stepfather Guardian
Name _____

Cell Phone _____

Home Phone _____

Work Phone _____

Social Security No. _____

Employer _____

Occupation _____

Responsible Party

Name _____

Home Phone _____

Work Phone _____

Primary Dental Insurance

Insurer's Name _____

Relationship _____

Birthdate _____

Social Security No. _____

Employer _____

Insurance Company _____

Group No. _____

Employee No. _____

Ins. Co. Address _____

Parent's Marital Status

Single Married Divorced Widowed Separated

CHILD'S HEALTH HISTORY

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits? **yes** **no**

Comments:

Has your child ever had any of the following:

Asthma	yes	no
Cancer/Hepatitis	yes	no
HIV/AIDS	yes	no
Hemophilia	yes	no
Diabetes	yes	no
Allergies/Sinus	yes	no
Congenital Heart Defect	yes	no
Handicapped/Disabilities	yes	no
Convulsions/Epilepsy	yes	no
Tuberculosis	yes	no
Psychiatric/Psychological Care	yes	no
Attention Deficit	yes	no
Chemical Dependency	yes	no
Abnormal Bleeding	yes	no
Heart Murmur	yes	no

Type:

Rheumatic Fever	yes	no
Surgery	yes	no

Child's Habits

How often does your child brush?

How often does your child floss?

Date of last dental visit:

Previous Dentists:

Child's Physician:

Physician's Phone Number:

Child's Birthdate:

Is your child's water fluoridated? **yes** **no** **don't know**

Does your child take fluoride supplements? **yes** **no**

Does your child:

Suck thumb/finger	yes	no
Suck/bite lip	yes	no
Bite/chew nails	yes	no
Chew hard objects (pencils, etc.)	yes	no
Grind teeth	yes	no
Clench jaws	yes	no

Please explain any medical problems that you child has:

Dr. Winker's Review

Date _____ Signed Dr. _____

.....

I understand the above information is necessary to provide my dependent with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. 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 any changes in my dependents health or medication.

Parent/Guardian Signature _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Wade Winker to submit claims for payment for services to the insurance companies of my behalf and assign to him the group insurance benefits otherwise payable to me. I understand that I am responsible for any charges not covered by my insurance benefits.

Parent/Guardian Signature _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(Name of Patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-½ % late charge (18% APR) may be added to my account.

Parent/Guardian Signature _____ Date _____ Relationship to Patient _____