PRESCOTT
Family Dental

We WELCOME your child

to our dental office. Our goal is to help you and your child reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for your child.

About Your Child

Today's Date:_____

Child's Name: _____

They prefer to be called:_____ M ❑ F ❑

Birth date:____ /____ /____ Age:____

Home Address:_____

City, State, Zip: _____

Hm#: ( )_____Cell#:( )_____

Are we able to confirm appointments by:

Text: yes ❑ no ❑ Email: yes ❑ no ❑

Email: _____

Whom may we thank for referring you?_____

Other family members seen by us?_____

Previous Dentist:_____

Date of last visit:_____

Parent/Guardian Information

Your Name: _____Relationship: _____

Cell#_____Home# _____

Home Address:_____

City, State, Zip:_____

Birthdate:____ / ____ / ____

Parent/Guardian #2

Name: _____Relationship: _____

Cell#_____Home# _____

Home Address:_____

City, State, Zip:_____

Birthdate:____ / ____ / ____

HIPAA

I have received a copy of this office's Notice of Privacy Practices

Parent or Guardian Signature:_____

Date:_____

Primary Dental Insurance

Insured's Name:_____Relationship:_____

Insured's Employer_____

Group# (Plan, Local or Policy#)_____

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

Insured's Birthdate:____ / ____ / ____

Insured's SS# or ID#_____

Secondary Dental Insurance

Insured's Name:_____Relationship:_____

Insured's Employer_____

Group# (Plan, Local or Policy#)_____

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone#: ( )_____

Insured's Birthdate:____ / ____ / ____

Insured's SS# or ID#_____

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dentist (or dental group) insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over 90 days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

Parent or Guardian Signature:_____

Date:_____

Our office is HIPAA compliant and is meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Medical History

Patient Name_____ Birth Date_____

Although dental personnel primarily treat the area in and around your child's mouth, your child's mouth is a part of their entire body. Health problems that they may have, or medication that they may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the following questions.

Is your child currently in pain? O Yes O No What is the primary reason for today's visit?_____
Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? O Yes O No
Has the child experienced problems with previous dental work? O Yes O No
Is the child's water fluoridated? O Yes O No Is the child taking fluoridated supplements? O Yes O No
Does the child brush their teeth daily? O Yes O No Floss their teeth daily? O Yes O No

Does/Did the child have any of the following habbits?

Breast Fed	O	Yes	O	No	Mouth Breather	O	Yes	O	No	Thumb/Finger Sucking	O	Yes	O	No
Chewing on Objects?	O	Yes	O	No	Nail Biting	O	Yes	O	No	Tongue/Cheek Biting	O	Yes	O	No
Clenching/Grinding Teeth	O	Yes	O	No	Nursing Bottle Habits	O	Yes	O	No	Tongue Thrust	O	Yes	O	No
Lip Sucking/Biting	O	Yes	O	No	Speech Problems	O	Yes	O	No	Used Pacifier	O	Yes	O	No

Is your child under a physician's care now? O Yes O No If yes, please explain:_____
Have they ever been hospitalized or had a major operation? O Yes O No If yes, please explain:_____
Have they ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Are they taking any medications, pills, or drugs? O Yes O No If yes, please explain:_____
Are they on a special diet? O Yes O No Do they use tobacco? O Yes O No
Do they use controlled substances? O Yes O No Taking oral contraceptives? O Yes O No

Are they allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐Other If yes, please explain:_____

Do they have, or have they had, any of the following?

AIDS /HIV Positive	O	Yes	O	No	Cortisone Medicine	O	Yes	O	No	Hemophilia	O	Yes	O	No	Radiation Treatments	O	Yes	O	No
Alzheimer's Disease	O	Yes	O	No	Diabetes	O	Yes	O	No	Hepatitis A	O	Yes	O	No	Recent Weight Loss	O	Yes	O	No
Anaphylaxis	O	Yes	O	No	Drug Addiction	O	Yes	O	No	Hepatitis B or C	O	Yes	O	No	Renal Dialysis	O	Yes	O	No
Anemia	O	Yes	O	No	Easily Winded	O	Yes	O	No	Herpes	O	Yes	O	No	Rheumatic Fever	O	Yes	O	No
Angina	O	Yes	O	No	Emphysema	O	Yes	O	No	High Blood Pressure	O	Yes	O	No	Rheumatism	O	Yes	O	No
Arthritis/Gout	O	Yes	O	No	Epilepsy or Seizures	O	Yes	O	No	High Cholesterol	O	Yes	O	No	Scarlet Fever	O	Yes	O	No
Artificial Heart Valve	O	Yes	O	No	Excessive Bleeding	O	Yes	O	No	Hives or Rash	O	Yes	O	No	Shingles	O	Yes	O	No
Artificial Joint	O	Yes	O	No	Excessive Thirst	O	Yes	O	No	Hypoglycemia	O	Yes	O	No	Sickle Cell Disease	O	Yes	O	No
Asthma	O	Yes	O	No	Fainting Spells/Dizziness	O	Yes	O	No	Irregular Heartbeat	O	Yes	O	No	Sinus Trouble	O	Yes	O	No
Blood Disease	O	Yes	O	No	Frequent Cough	O	Yes	O	No	Kidney Problems	O	Yes	O	No	Spina Bifida	O	Yes	O	No
Blood Transfusion	O	Yes	O	No	Frequent Diarrhea	O	Yes	O	No	Leukemia	O	Yes	O	No	Stomach/Intestinal Dis.	O	Yes	O	No
Breathing Problem	O	Yes	O	No	Frequent Headaches	O	Yes	O	No	Liver Disease	O	Yes	O	No	Stroke	O	Yes	O	No
Bruise Easily	O	Yes	O	No	Genital Herpes	O	Yes	O	No	Low Blood Pressure	O	Yes	O	No	Swelling of Limbs	O	Yes	O	No
Cancer	O	Yes	O	No	Glaucoma	O	Yes	O	No	Lung Disease	O	Yes	O	No	Thyroid Disease	O	Yes	O	No
Chemotherapy	O	Yes	O	No	Hay Fever	O	Yes	O	No	Mitral Valve Prolapse	O	Yes	O	No	Tonsillitis	O	Yes	O	No
Chest Pains	O	Yes	O	No	Heart Attack/Failure	O	Yes	O	No	Osteoporosis	O	Yes	O	No	Tuberculosis	O	Yes	O	No
Cold Sores/Fever Blisters	O	Yes	O	No	Heart Murmur	O	Yes	O	No	Pain in Jaw Joints	O	Yes	O	No	Tumors or Growths	O	Yes	O	No
Congenital Heart Disorder	O	Yes	O	No	Heart Pacemaker	O	Yes	O	No	Parathyroid Disease	O	Yes	O	No	Ulcers	O	Yes	O	No
Convulsions	O	Yes	O	No	Heart Trouble/Disease	O	Yes	O	No	Psychiatric Care	O	Yes	O	No	Venereal Disease	O	Yes	O	No
Yellow Jaundice	O	Yes	O	No															

Have they ever had any serious illness not listed above? O Yes O No

Dental Concerns or Medical Concerns: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient Parent or Guardian_____ Date_____