



Patient and Family Information

Child's Name _____ Birthdate _____ Male Female

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Responsible Party _____

Relationship to Child _____

Name of Mother/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Name of Father/Guardian _____ Birthdate _____

Social Security # _____ Home Phone _____

Address _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____

Cell Phone _____ E-mail _____

Child's Dental History

Former Dentist _____ Office Phone _____

Address _____

City _____ State _____ Zip _____

Date of last dental visit _____

How often does your child brush? _____

How often does your child floss? _____

- Please check all that apply to your child:
- | | | |
|---|---|---|
| <input type="checkbox"/> Thumb/Finger Sucking | <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Grinding Teeth |
| <input type="checkbox"/> Lip or Cheek Biting | <input type="checkbox"/> Jaw Difficulty: Clicking and/or Pain | |

Child's Health History

- Please check all that apply to your child:
- | | | | |
|------------------------------------|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis - Type _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tonsillitis | _____ |



Primary Dental Insurance

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Person Responsible for Account _____
Relationship to Patient _____ Birthdate _____
Social Security # _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to Pediatric Dentistry @ Lake Nona
for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

