Welcome to Indiana Family Dentistry, LLC

INFORMATION

1 ABOUT YOUR CHILD

Today's Date: ____ /____ /____

CHILD'S NAME: _____
LAST FIRST MI.

Child's Nickname: _____ Boy Girl

Child's Birthdate: ____ /____ /____ Age _____

School: _____ Grade: _____

Child's Home Phone#: (_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

2 INSURANCE INFO

PRIMARY DENTAL INSURANCE

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone#: _____

Insured's SS#: _____

Group# (Plan, Local, or Policy#): _____

Insured's Name: _____

Relation: _____ Birthdate: ____ /____ /____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone#: _____

Insured's SS#: _____

Group# (Plan, Local, or Policy#): _____

Insured's Name: _____

Relation: _____ Birthdate: ____ /____ /____

Insured's Employer: _____

3 CHILD'S FAMILY INFO

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? Yes No

How many Brothers/Sisters? ____ Age(s): ____ ____ ____

Mother's Name: _____
STEP MOTHER GUARDIAN

_____
CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(____) _____ (____) _____ _____
HOME PHONE# WORK PHONE# EXT.

_____ _____
MOTHER'S SOCIAL SECURITY# MOTHER'S DRIVERS LIC.#

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
STEP FATHER GUARDIAN

_____
(○**CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(____) _____ (____) _____ _____
HOME PHONE# WORK PHONE# EXT.

_____ _____
FATHER'S SOCIAL SECURITY# FATHER'S DRIVERS LIC.#

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 ACCOUNT INFO

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

SS#: _____

Drivers License#: _____

Work Phone#: (____) _____

Payment method: Cash Check

_____
Credit Card-Enter card # above (If accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

PLEASE CONTINUE ON BACK ▶

5 CHILD'S DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation

Is Child in pain? No Yes How Long? _____

Please indicate ✓ any of the following problems:

Discomfort, clicking or popping in jaw	Lost/broken filling(s)	Broken/chipped tooth
Red, swollen or bleeding gums	Teeth grinding	Stained teeth
Sensitive tooth, teeth or gums	Ringing in ears	Locking jaw
Bad breath	Blisters/sores in or around mouth	Loose tooth

Other(s): _____

Does child require pre-medication? Yes No Don't Know

Previous Dentist _____ (_____) _____
Name Phone#

Last Dental exam: _____ /_____ /_____ Last Dental X-rays: _____ /_____ /_____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? Yes No

How would you rate the child's smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

6 MEDICAL HISTORY

IF CHILD HAS (OR BEEN TOLD THEY HAVE) ANY OF THE FOLLOWING, PLEASE CHECK Y OR N.

Heart Murmur	Y N	Chemotherapy	Y N	Anemia	Y N	Organ Problems	Y N
Rheumatic fever	Y N	Jaw Problems TMJ / TMD	Y N	Diabetes / Hypoglycemia	Y N	HIV+ / AIDS / ARC	Y N
Artificial Heart Valves	Y N	Tonsillitis	Y N	Hemophilia	Y N	Tuberculosis TB	Y N
Congenital Heart Defect	Y N	Respiratory Problems	Y N	Abnormal Bleeding	Y N	Psychiatric Problems	Y N
Scarlet Fever	Y N	Asthma / Difficulty Breathing	Y N	High / Low Blood Pressure	Y N	Hyper Active / ADD	Y N
Surgeries/Operations	Y N	Blood Transfusion(s)	Y N	Hepatitis	Y N	Fainting / Seizures / Epilepsy	Y N
Cancer/Tumors	Y N	Leukemia	Y N	Artificial Bone / Joints / Implan	Y N		

Please list any other medical condition(s) your child has or ever had: _____

IS CHILD ALLERGIC TO:

Latex	Y N	Sulfa	Y N	Aspirin	Y N	Food Allergies	Y N
Penicillin / Amoxicillin	N	Dental Anesthetics (Novocaine	Y N	Others: _____			

DOES CHILD DO ANY OF THE FOLLOWING:

Thumb / Finger Sucking	Y N	Tongue Thrusting / Sucking	Y N	Heavy Snoring	Y N	Mouth Breathing	Y N
Lip Sucking / Biting	Y N						

IS CHILD TAKING ANY OF THE FOLLOWING:

Pain Medication	Y N	Ritalin	Y N	Blood Thinners	Y N	Insulin	Y N
(Including Aspirin)		Stimulants	Y N	Tranquilizers	Y N	Muscle Relaxers	Y N

Other: _____

Please rate the child's general health from 1-10: _____ Does child wear contact lenses? Y N

Childs Physician: _____ (_____) _____ - _____
DOCTOR'S NAME OR CLINIC NAME Phone Number

7 INDIANA FAMILY DENTISTRY, LLC PATIENT CONSENT

The undersigned hereby authorizes the treating Dentists, employed by Indiana Family Dentistry, L.L.C. to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to preform any and all forms of treatment, medication

and therapy, that may be indicated in connection with (name of Patient) _____
and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% Annually) will be added to any balance over 80 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient: _____ Date: _____ Witness: _____

If Patient is Minor, Signature
of Responsible Party or Parent _____ Relationship to Patient: _____

INSURANCE ASSIGNMENT:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed: _____ Date: _____