COMFORT CARE
Family Dental, P.C.

Welcome

Date _____ Birthdate _____

Name of Minor/Child _____ Sex ❑ M ❑ F Age _____
Last First Middle Initial

Nickname _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone ( )_____

Person Financially Responsible _____ Home ( ) _____ Cell ( ) _____

Whom may we thank for referring you? _____

Primary Insurance Information

Insurance Plan Name _____ Group # _____ ID # _____

Insurance Address _____
Street City State Zip

Patient's Relationship to Primary Holder ❑ Child ❑ Self ❑ Spouse ❑ Other

Name of Insurance Holder _____ Insured's Birthdate _____
Last First Middle Initial

Insurance Holder's Address _____
Street City State Zip

Employer's Name _____

Employer's Address _____
Street City State Zip

Secondary Insurance Information

Insurance Plan Name _____ Group # _____ ID # _____

Insurance Address _____
Street City State Zip

Patient's Relationship to Holder ❑ Child ❑ Self ❑ Spouse ❑ Other

Name of Insurance Holder _____ Insured's Birthdate _____
Last First Middle Initial

Insurance Holder's Address _____
Street City State Zip

Employer's Name _____

Employer's Address _____
Street City State Zip

Medical History

Medications_____

Allergies Please check all that apply:

❑Aspirin	❑Iodine	❑Local Anesthetics
❑Latex	❑Penicillin	❑Barbituates (Sleeping pills)
❑Sulfa	❑Codeine	❑Other _____

Primary Physician Contact Information_____Phone ( )_____

Dental History

Date of last visit to the dentist _____ Has the child complained about dental problems? Yes ❑ No ❑

Date of last x-rays, exams, cleaning _____ Does the child brush teeth daily? Yes ❑ No ❑

Former Dentist Name_____ Does the child floss every day? Yes ❑ No ❑

_____ Is fluoride taken in any form? Yes ❑ No ❑

Any injuries to the mouth, teeth, head? Yes ❑ No ❑

Any unhappy dental experiences? Yes ❑ No ❑

Has the minor/child had any history of or difficulty with any of the following?

❑A.I.D.S/ H.I.V.	❑Cerebral Palsy	❑Mouth Breathing	❑Heart Problems	❑Mumps
❑Anemia	❑Chicken Pox	❑Pacifier	❑Hepatitis	❑Rheumatic Fever
❑Asthma	❑Convulsions	❑Sleeping with a Bottle	❑Kidney Disease	❑Sinus Problems
❑Bladder Problems	❑Diabetes	❑Epilepsy	❑Liver Disease	❑Thyroid Disease
❑Cancer	❑Drug/Alcohol Abuse	❑Fainting	❑Measles	❑Tuberulosis
❑Thumbsucking	❑Nail Biting	❑Hearing Problems	❑Mononucleosis	❑Other_____

Emergency Contact

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone( )_____

Name_____ Relationship_____ Phone( )_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____ and assign directly to Comfort Care Family Dental P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Comfort Care Family Dental P.C. may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Parent, Guardian or Personal Representative | Relationship to Patient