Patient Information

Tell us about your Child

Childs's Name:

_____

Last First MI

Child's Birth Date: _____ ☐ Male ☐ Female

Preferred Name: _____

Child's Home Address:

_____

Street Apt. No.

_____

City State Zip Code

Child lives with: _____

Parent's Information

☐ **Mother** ☐ Stepmother ☐ Guardian

Name: _____

Date of Birth: _____

Home Ph: _____

Work Ph: _____ Cell_____

Employer_____

Social Security Number: _____

☐ **Father** ☐ Stepfather ☐ Guardian

Name: _____

Date of Birth: _____

Home Ph: _____

Work Ph: _____Cell_____

Employer_____

Social Security Number: _____

The best number to confirm appointments is:

_____

E-mail address:

_____

Person Responsible for Account

Name: _____

Billing Address:

_____

Street Apt. No.

_____

City _____

State _____ Zip Code _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Relationship _____

Emergency Contact: _____

Contact's phone No. _____

Please list all medications that the child is currently taking:

_____

_____

Please list any drugs that cause an allergic reaction:

_____

_____

Y N Thumb/ Finger sucking
Y N Speech problems
Y N Tongue Thrust
Y N Pacifier
Y N Lip sucking /Biting
Y N Nail Biting
Y N Chewing on Objects
Y N Clenching/ Grinding

Is your child under the care of a Physician? _____

Child's Physician_____

Physician's Phone number_____

Is the child taking fluoride supplements? **Y** N

Completed forms can be returned by fax (509-232-0555), e-mail (info@braundentalcare.com), or in person. We look forward to seeing you soon!

Continued on next page

Has the Child experienced the following medical Problems?

Y N Abnormal Bleeding	**Y** N Convulsions	**Y** N Hives
Y N AIDS/HIV	**Y** N Diabetes	**Y** N High Blood Pressure
Y N Anemia	**Y** N Epilepsy	**Y** N Kidney Problems
Y N Any Hospital Stays	**Y** N Exposed to HIV/ but negative	**Y** N Liver Problems
Y N Any Operations	**Y** N Handicaps/ Disabilities	**Y** N Measles
Y N Asthma	**Y** N Hearing impairment	**Y** N Mononucleosis
Y N Cancer	**Y** N Heart Murmur	**Y** N Rheumatic Fever
Y N Chicken Pox	**Y** N Hemophilia	**Y** N Scarlet Fever
Y N Congenital heart Defect	**Y** N Hepatitis	**Y** N Tuberculosis (TB)

Is there anything you would like to discuss with the Doctor in private? ☐ yes ☐ No

Please list any serious medical problems the child experiences/ed:_____

_____

Dental Insurance Information

Primary Insurance

Name of Insured_____

Date of Birth_____

Soc. Sec. or Id Number_____

Address_____

_____

Home Ph. _____Work Ph. _____

Employer Address_____

_____

Insurance Plan Name and Address: _____

_____

_____

Group Number: _____

Other Insurance

Name of Insured _____

Date of Birth _____

Soc. Sec. or Id Number_____

Address_____

_____

Home Ph. _____Work Ph. _____

Employer Address_____

_____

Insurance Plan Name and Address: _____

_____

_____

Group Number: _____

Consent Statement

I hereby authorize and request the performance of dental services for myself or for: _____

_____

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment. *I understand and acknowledge that I am financially responsible for these services provided for myself or the above named, regardless of insurance coverage. I also understand that the treatment estimate presented to me is only an estimate.* Occasionally, the need may arise to modify treatment, and in such a case, I will be informed of the need for additional treatment, and its fee modification. I understand this office will help me utilize my insurance benefits. Ultimately I am responsible for knowing my insurance plan and paying all balances left after insurance pays.

We may report information about your account to credit bureaus. Late Payment, missed payments or other defaults on your account may be reflected in your credit report.

I understand I will be charged $35.00 for all failed appointments without 24 hours notice.

To the best of my knowledge the information provided is this form is accurate.

_____ _____

Signature of patient, parent or guardian Date