



Welcome!

Patient Information (Confidential)

Child's Name _____ Birthdate _____ Gender _____
Parent/Guardian Name _____ SocialSN _____ DL# _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
E-Mail _____
Employer _____ Occupation _____ How Long There? _____
Other parent/guardian _____ Soc Sec.# _____
Other Parent's Employer _____ Occupation _____ How Long There? _____
If patient is a student: Name of School/College _____ Full-time or part? _____
How did you hear about our office? _____

Primary Insurance

Name of Insured _____
Birthdate _____ Relationship to patient _____
Insurance Company _____
Insurance Address _____
Insurance Phone _____
Soc.Sec.# _____
SubscriberID# _____
Group, Contract or Local or Union # _____

Additional Insurance

Name of Insured _____
Birthdate _____ Relationship to patient _____
Insurance Company _____
Insurance Address _____
Insurance Phone _____
Soc.Sec.# _____
SubscriberID# _____
Group, Contract or Local or Union # _____

Copayments

To accept insurance, we now debit copayments automatically to your credit card or bank account. If you would like us to accept your insurance, please provide credit card information or voided check.

MC VISA AMEX Discover Account # _____ Expiration Date _____
Name on Card _____ Billing Address _____
 Voided Check Attached

In case of emergency

Physician's name _____ City _____ Phone _____
Someone we may contact, not living with you _____ Phone _____

Agreement to pay for treatment and authorization to automate co-payments

I hereby acknowledge full responsibility for the payment of services rendered in behalf of the named patient whether or not they are covered by insurance. I understand payment is expected at the time of service. I understand that in certain circumstances my credit report may be requested. I understand that check payments may be converted to automatic bank drafts. I agree that if payment is extended beyond 30 days from the date of service to pay a rebilling charge of 1.7% of the unpaid balance, with minimum rebilling charge of \$5.00 per month. I agree to pay collections costs and/or attorney's fees if a delinquent balance is placed with an agency for collection. I authorize my insurance company to make payments directly to the dental office for the benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I have received a copy of this office's Notice of Privacy Practices. I understand that appointments missed or cancelled without 24 hours notice are subject to a \$35 cancellation fee. I understand that a deposit may be required to reserve certain appointment types and/or times. I understand estimates of treatment cost are valid for 90 days. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature: _____ Date _____

Medical History

Have your child been hospitalized? Please explain. _____

Is your child under the care of a physician or planning to see one for any reason? Please explain. _____

List any medications your child is currently taking. _____

Allergies: penicillin sulfa local anesthetics codeine latex metal other _____

Please check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Disease/Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Liver Disease/Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart attack/failure | <input type="checkbox"/> Lung Disease/Problems | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mitral valve prolapsed | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Pain in jaw joints | <input type="checkbox"/> STD/Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart trouble/Disease | <input type="checkbox"/> Parathyroid disease | |

Any other illness not checked above _____

Please indicate if you would prefer to speak privately with the dentist about a medical issue: yes no

Dental History

Reason for seeking care today: Exam Cleaning Specific Problem _____

Please check all that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Bite or teeth shifted | <input type="checkbox"/> Clench or Grind teeth | <input type="checkbox"/> Embarrassed about teeth |
| <input type="checkbox"/> Broken filling or tooth | <input type="checkbox"/> Bite cheeks | <input type="checkbox"/> Clicking or popping jaw joint | <input type="checkbox"/> Gag easily |
| <input type="checkbox"/> Chipped tooth or teeth | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Unable to open wide | <input type="checkbox"/> Dislike dental office noises |
| Sensitivity to: | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Jaw tires easily | <input type="checkbox"/> Don't like cotton in mouth |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Unhappy with previous dental work | <input type="checkbox"/> TMJ or TMD | <input type="checkbox"/> Uncomfortable lying in dental chair |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Gums bleed | <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Afraid of needles |
| <input type="checkbox"/> Sweets | <input type="checkbox"/> Gums tender | <input type="checkbox"/> Had braces | <input type="checkbox"/> Difficult to numb |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Growths or sores | <input type="checkbox"/> Want braces | <input type="checkbox"/> Reaction to anesthetic |
| <input type="checkbox"/> Food Catches | <input type="checkbox"/> Cold sores/fever blisters | <input type="checkbox"/> Prior gum treatment | <input type="checkbox"/> Worried about costs |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Cracked/chapped lips | <input type="checkbox"/> Prior bite treatment | <input type="checkbox"/> Worried about time |
| <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Bad taste in mouth | <input type="checkbox"/> Snore or don't sleep well | |
| <input type="checkbox"/> Floss breaks or hurts | | <input type="checkbox"/> Play sports | |

Would you like whiter teeth? yes no Is there anything that bothers you (even just a little) about the appearance of your teeth or smile? _____

On a scale from 1-10 how anxious are you about dental treatment?(1=relaxed, 10=scared) _____

What did you like most about your child's last dentist? _____

Why did you leave your last dentist? _____

Is there anything we can do to make your child's visits more comfortable? _____

Consent for treatment

To the best of my knowledge the questions on this form have been accurately answered. I will inform Legacy Dental of any changes to these answers. I authorize Legacy Dental and its associates to perform those procedures deemed necessary or advisable to maintain my dental health or the dental health of my child. I understand that dental treatment and anesthesia entails risks such as bleeding, infection, nerve damage, fracture of teeth or bone, injury to muscles, bruising, muscle soreness, swallowing or inhaling small objects, breakage of instruments, pain during and after treatment, abrasions and lacerations to gums, cheeks, or tongue. I do voluntarily assume all possible risks that may be associated with dental treatment in hopes of obtaining the desired results.

Signature: _____ Date: _____