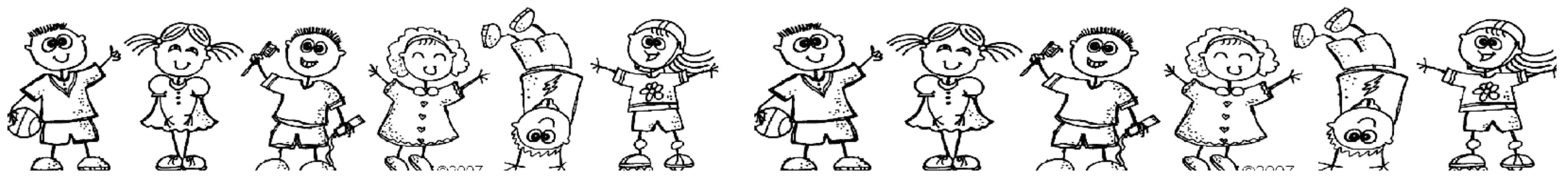

DENTISTRY FOR CHILDREN

PATIENT INFORMATION

CHILD'S NAME – FIRST	MIDDLE	LAST	NICKNAME	AGE	DATE OF BIRTH ☐ M ☐ F

SCHOOL	GRADE	REASON FOR VISIT

INCASE OF EMERGENCY, WHO MAY WE CONTACT? NAME	PHONE NUMBER	RELATIONSHIP

HOW WERE YOU REFERRED TO OUR OFFICE? (WE WISH TO THANK THEM)

MEDICAL HISTORY

CHILD'S PHYSICIAN – NAME & ADDRESS	PHONE #	DATE LAST SAW PHYSICIAN ______ MONTH / YEAR

		YES	NO
1.	IS YOUR CHILD PRESENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEM? WHAT? ______	☐	☐
2.	IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? WHAT? ______	☐	☐
3.	HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY? FOR WHAT? ______ WHEN? ______	☐	☐
4.	IS YOU CIHLD ALLERGIC TO ANY FOOD OR MEDICINE? WHAT? ______	☐	☐

HAS YOUR CHILD HISTORY OF? **(CHECK IF YES)**

- ☐ HEART TROUBLE OR MURMURS
- ☐ RHEUMATIC FEVER
- ☐ ALLERGIES
- ☐ DRUG SENSITIVITIES
- ☐ SEIZUERS / CONVULSIONS
- ☐ AIDS / HIV POSITIVE
- ☐ BRAIN INJURY
- ☐ DIABETES
- ☐ ASTHMA
- ☐ EPILEPSY
- ☐ BLOOD TRANSFUSIONS
- ☐ KIDNEY / LIVER INVOLMENT
- ☐ HEPATITIS
- ☐ BLEEDING PROBLEMS
- ☐ BLOOD DISORDERS
- ☐ HEADACHES

IS THERE ANYTHING ELSE REGARDING YOUR CHILD'S PHYSICAL, MENTAL, OR EMOTIONAL HEALTH THAT YOU FEEL WE SHOULD KNOW? WHAT?

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT? ☐ YES ☐ NO	PREVIOUS DENTIST	CITY	DATE OF LAST VISIT

ANY INJURY TO YOUR CHILD'S TEETH OR JAWS? (FALLS BLOWS, CHIPS, ETC.) ☐ YES ☐ NO	HISTORY OF? ☐ THUMB SUCKING ☐ LIP SUCKING ☐ PACIFIER ☐ FINGER SUCKING ☐ NAIL BITTING

HAS YOUR CHILD EXPERIENCE ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE? ☐ YES ☐ NO	EXPLAIN

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST?	AGE OF CHILD WHEN DISCONTINUED BOTTLE OR NURSING. (FOR CHILDREN UNDER 3)

PREVENTATIVE DENTAL HISTORY

HOW OFTEN DOES CHILD BRUSH?	IS TOOTHBRUSHING SUPERVISED? ☐ YES ☐ NO	BY WHOM?	WHEN?

IS DENTAL FLOSS USED? ☐ YES ☐ NO	DOES YOUR CHILD RECEIVE? (CHECK IF YES) ☐ FLUORIDE IN VITAMINS ☐ FLUORIDE TABLETS / DROPS ☐ BOTTLED FLUORIDATED WATER ☐ NONE

↓ **OVER PLEASE** ↓

RESPONSIBLE PARTY

PLEASE NOTE: IF THE FAMILY IS NOT LIVING TOGETHER, THE PARENT ACCOMPANYING THE CHILD IS RESPONSIBLE FOR THE ACCOUNT.

FATHERS FULL NAME	DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYED BY	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	EMAIL

HOME PHONE #	CELL PHONE #	WORK OR OTHER #

RESIDENCE ADDRESS	STATE	ZIP CODE

MOTHERS FULL NAME	DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYED BY	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	EMAIL

HOME PHONE #	CELL PHONE #	WORK OR OTHER #

RESIDENCE ADDRESS	STATE	ZIP CODE

INSURANCE INFORMATION

NAME OF INSURED	NAME OF DENTAL INSURANCE CO.

INSURANCE PHONE #	INSURANCE ID	GROUP ID

INSURANCE ADDRESS

DO YOU HAVE ADDITIONAL INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING

NAME OF INSURED	NAME OF DENTAL INSURANCE CO.

INSURANCE PHONE #	INSURANCE ID	GROUP ID

INSURANCE ADDRESS

NAMES OF THE CHILD'S BROTHERS AND SISTERS AND THEIR BIRTHDATES

HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? ☐ YES ☐ NO
IF YES, NAME

FINANCIAL AGREEMENT

I HEREBY AUTHORIZE DR. ERIK ROOKLIDGE AND/OR HIS ASSOCIATES TO PROVIDE DENTAL TREATMENT FOR MY ABOVE NAMED CHILD. I CONSENT TO SUCH TREATMENT, MEDICATIONS, AND TREATMENT METHODS AS DR. ROOKLIDGE AND HIS ASSOCIATES AND STAFF DEEM APPROPRIATE IN PROVIDING THE SAFEST AND BEST POSSIBLE DENTAL CARE FOR MY CHILD. I UNDERSTAND THAT PRIOR TO ANY TREATMENT BEING RENDERED, A FULL EXPLANATION OF THE DIAGNOSIS, PROCEDURES, ALTERNATIVE TREATMENT AND CONSEQUENCES OF NO TREATMENT WILL BE GIVEN.

OUR TREATMENT IS RENDERED TO YOUR CHILD, NOT THE INSURANCE COMPANY; THEREFORE, YOU ARE RESPONSIBLE TO US FOR SERVICES PROVIDED. OUR OFFICE WILL BILLYOUR INSRUANCE AT NO CHARGE, AS A COURTESY TO YOU. WE WILL DO OUR BEST TO CORRECTLY ESTIMATE YOUR PORTION OF THE TOTAL CHARGES BILLED**. HOWEVER, THIS IS ONLY AN ESTIMATE. YOU INSURANCE DETERMINES YOUR EXACT BENEFITS.** WE WILL COLLECT YOUR ESTIMATED PORTION AT THE TIME SERVICES ARE RENDERED. IF THERE IS NO PAYMENT MADE THE DAY OF SERVICES, A BILLING CHARGE WILL BE INCURRED. IF THERE ARE ANY CONCERNS ABOUT THE AMOUNT YOUR INSURANCE COMPANY HAS PAID, PLEASE CONTAC TTHEM TO GO OVER YOUR POLICY. IF THERE IS A REFUND DUE TO YOU AFTER YOUR INSURANCE COMPANY PAYS, WE WILL SEND IT TO YOU ONCE WE HAVE RECEIVED ALL INSURANCE PAYMENTS.

I AGREE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR MY CHILD'S DENTAL CARE AND TREATMENT WITH DR. ERIK ROOKLIDGE AND/OR ASSOCIATES. I AGREE TO PAY A FINANCE CHARGE OF ONE AND ONE-HALF PERCENT PER MONTH ON ALL AMOUNTS DUE AND OWING DR. ROOKLIDGE. IF ANY LEGAL ACITON IS NECESSARY TO ENFORCE THE TERMS OF THIS AGREEMENT, OR IF IS NECESSARY TO EMPLOY AN ATTORNEY TO ENFORCE THE TERMS OF THIS AGREEMENT, THE PARTY IN DEFAULT OR IN BREACH HEREOF AGREES TO PAY THE OTHER PARTY'S REASONABLE ATTORNEY'S FEES AND COURT COSTS. I AGREE TO PAY UP TO A 40% COLLECTION EXPENSE INCURRED BY DR. ERIK ROOKLIDGE IN ATTEMPTING TO COLLECT SUCH AMOUNTS FROM ME, IN ADDTION TO THE AFOREMENTIONED ATTORNEY'S FEES AND COSTS.

SIGNATURE	RELATIONSHIP TO CHILD	DATE