Child Form

This information is important to verify your child's identity at any time, and to fully access your insurance benefits.

AestheticDentistry OF STUART

PATIENT NAME _____ PREFERRED NAME _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH _____

GUARDIAN 1 NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EMAIL _____

GUARDIAN 2 NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ EMAIL _____

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED

CHILD LIVES WITH: ☐BOTH PARENTS ☐MOTHER ☐FATHER ☐LEGAL GUARDIAN ☐OTHER _____

Additional Person to contact in case of emergency:

NAME _____ RELATIONSHIP _____ PHONE _____

Who is accompanying the child to their dental visit today? NAME _____ RELATIONSHIP _____

PRIMARY DENTAL INSURANCE

MAIN POLICY HOLDER _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ CHILD ☐ OTHER _____

INSURANCE PLAN NAME _____ EMPLOYER _____

ID # _____ GROUP # _____

I authorize my insurance company to pay Aesthetic Dentistry of Stuart all insurance benefits rendered.
I authorize the dentist to release all information necessary to secure the payment of my benefits.
I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature _____

PREVIOUS DENTIST _____ LAST VISIT _____ X-RAYS TAKEN: ☐ YES ☐ NO

Has your child had braces or are they under the supervision of an Orthodontist? ☐ YES ☐ NO

If yes, what is the name and phone number of the Orthodontist? _____

PHONE _____ WHOM MAY WE THAN FOR REFERRING YOU TO US? _____

PATIENT'S HEALTH HISTORY

Is your child being treated by a physician at this time?If ☐ YES ☐ NO

yes, please indicate the reason why? _____

Primary Physician/Pediatrician Name: _____ Phone _____

Please mark yes/no if your child has a history of the following conditions.

For each "Yes" provide details below.

ADD/ADHD	☐YES ☐NO	Lung Disease	☐YES ☐NO	Ear infections	☐YES ☐NO
Artificial Bones	☐YES ☐NO	Reflux	☐YES ☐NO	GERD	☐YES ☐NO
Artificial Valves/Joints	☐YES ☐NO	Speech Impediment	☐YES ☐NO	Handicapped/Disabilities	☐YES ☐NO
Congenital Heart Defect	☐YES ☐NO	Substance Abuse	☐YES ☐NO	Heart Disease	☐YES ☐NO
Diabetes	☐YES ☐NO	Tuberculosis	☐YES ☐NO	Hepatitis	☐YES ☐NO
Epilepsy/Seizures	☐YES ☐NO	Anemia	☐YES ☐NO	Kidney Problems	☐YES ☐NO
GI Disorder	☐YES ☐NO	Asthma	☐YES ☐NO	Mental Illness	☐YES ☐NO
Hearing loss	☐YES ☐NO	Bleeding Disorder	☐YES ☐NO	Sensory Issues	☐YES ☐NO
Hemophilia	☐YES ☐NO	Cancer	☐YES ☐NO	Thyroid Issues	☐YES ☐NO
HIV	☐YES ☐NO	Developmental Delay	☐YES ☐NO	Vision loss/problems	☐YES ☐NO

Please describe any condition not listed: _____

Does your child have any allergies? ☐ YES ☐ NO

Please explain/clarify any conditions or allergies selected above: _____

Be specific: Allergies/Conditions: _____

Is your child taking any medication (prescription or over the counter) vitamins, or dietary supplements ?

☐ YES ☐ NO List name: _____

Has your child been hospitalized or had surgery? ☐ YES ☐ NO

If yes, list date and describe: _____

Has your child ever had a reaction or problem with an anesthetic? ☐ YES ☐ NO

If yes, describe: _____

Are your child's immunizations up to date: ☐ YES ☐ NO

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your child's dental treatment:

_____

Is there any other medical history pertaining to your child to discuss with the doctor in private? ☐ YES ☐ NO

I understand the information I have given is true and correct to the best of my knowledge, it will be held at the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of parent or legal guardian **Date**

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