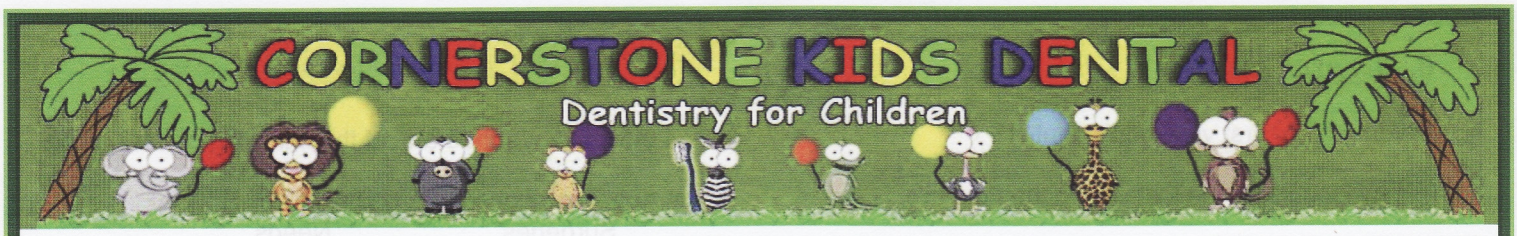

Welcome!! We are happy to have you here! **Today's Date**_____

1. Tell Us About Your Child

Child's Name:_____
Goes by:_____ **Male / Female**
Siblings that we treat:_____
Child's Birthdate: ____/____/____ Child's Age:_____
School: _____ Grade:_____
Child's Home #: (____)_____-_____
SS#:_____-_____-_____
Home Address:_____
_____
City State Zip
Email Address:_____

2. Mother's Information

Name:_____
Circle one: Mother Stepmother Guardian
Birthdate _____/_____/_____
Billing Address:_____
_____
City State Zip
Employer:_____
Work # (_____) _____-_____ Ext. _____
Home # (_____)_____-_____
Cellular Phone # (_____) _____-_____
SS #:_____-____-_____ DL#:_____
Email:_____
Person Responsible for Account: YES NO

3. Father's Information

Name:_____
Circle one: Father Stepfather Guardian
Billing Address:_____
_____
City State Zip
Birthdate: _____/_____/_____
Employer: _____
Work #: (____) _____-_____ Ext. _____
Home #: (____) _____-_____
Cellular Phone #: (____) _____-_____
SS #:_____-____-_____ DL#: _____
Email:_____
Person Responsible for Account: YES NO

4. Who is Accompanying the Child Today?

Name:_____
Relationship:_____
Do you have legal custody of the child? YES NO

5. Referral

Who may we thank for referring you to our office?
_____
If found on the Internet, where did you find us?
(Search engine, directory)_____

6. Primary Dental Insurance

Insured Name:_____
Relationship:_____
Insurance Co. Name:_____
Insurance Co. Address:_____
_____
Insurance Co. Phone #: (____) _____-_____
Group # (Plan, Local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's Birthdate: _____/ _____/ _____
Social Security #:_____
Policy Owner's Employer:_____

7. Financial Responsibility and Release

I certify that my child is covered by an Insurance Co. and I assign all insurance benefits that would otherwise be payable to me be paid to Cornerstone Kids Dental. I understand that my dental Insurance carrier may pay less than the actual bill or estimate for services. I understand that it is my responsibility to know if Cornerstone Kids Dental is contracted, or in-network recognized by my insurance company. I also understand that I am responsible for the payment of services presented as well as any deductible, co-insurance, out-of-network amount, usual and customary limit, and any other type of benefit limitation for services my child or dependent receives that my insurance does not cover. I hereby authorize Cornerstone Kids Dental to disseminate any information necessary to ensure the payment of benefits and the use of this form in all the documents submitted to the insurance, both manually as well as electronically.

_____
Initial

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service

I understand that if I cannot keep my appointments the office will need **a 24 hour notice otherwise a $10 dollar fee will be applied to my account.**

_____
Initial

8. Dental History

Is this your child's first visit to the dentist? YES NO

If not, how long since the last visit to the dentist?

_____

Previous Dentist's Name:_____

Were any x-rays taken at previous dental visits? YES NO

Have there been any injuries to the teeth, face or mouth? YES NO

If yes, please explain:_____

_____

_____

Why did you bring the child to the dentist today?

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting
Y N Sleeping with a bottle
Y N Nail Biting
Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain:_____

_____

_____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his / her teeth daily? YES NO

How do you think your child will tolerate dental treatment? Good Fair Poor

9. Health Dental History

Has the child ever had any of the following conditions?

Y N Any Operations/ Surgeries
Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/ Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD
Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Products
Y N Diabetes
Y N Autism

Please discuss any serious medical conditions the child has had _____

_____

Please list all drugs the child is currently taking: _____

_____

_____

Please list all **ALLERGIES**: _____

_____

Is the child currently under the care of a physician? YES NO

Child's Physician: _____

Phone (____) _____-_____

Address:_____

_____

Please describe the child's current physical health... Good Fair Poor

Our office is committed to meeting and exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

Parents are welcomed to accompany their children during cleaning appointments! However, we ask that they remain in the waiting room during treatment/sedation appointments for safety reasons. *

1. Authorize

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian | Date | Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

_____ _____

Initials | Date

Doctor's Comments:_____

_____

_____