**Date: _____**

# Welcome Form

## Patient Information

**Name of Minor/ Child** _____ **Birth Date**_____
Last First MI

**SS/HIC/ Patient ID#**_____ Sex: □ F □ M Age_____

Nickname _____ Hobbies _____ Cell Phone (___) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Number (___) _____

## Insurance Information

**Person financially responsible**_____ **Home** (___) _____ **Work** (___) _____

Whom may we thank for referring you? _____

**Father's/ Guardian's Name**_____

Address (if different from patient's) _____

Home Phone (___) _____ Work Phone (___) _____
(If different from above) (If different from above)

E-mail_____

Employer_____

Soc. Sec. # _____ Birth Date _____

Do you have dental insurance coverage for minor/ child? □ Yes □ No

**Plan Name** _____ Phone (___) _____

Address_____

Group #_____ Policy# _____

***Is your child eligible for treatment under Medical Assistance? □ Yes □ No**

**Child's Medical Assistance I.D. #**_____

**Mother's/ Guardian's Name** _____

Address (if different from patient's) _____

Home Phone (___) _____ Work Phone (___) _____
(If different from above) (If different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birth Date _____

Do you have dental insurance coverage for minor/ child? □ Yes □ No

**Plan Name** _____ Phone (___) _____

Address _____

Group # _____ Policy # _____

## Health Information

Date of last visit to a dentist: _____ For what service? _____

| **Dental History:** | **YES** | **NO** |
|---|---|---|
| Has child complained about dental problems? | □ | □ |
| Is fluoride taken in any form? | □ | □ |
| Does child brush teeth daily? | □ | □ |
| Any injuries to mouth, teeth, or head? | □ | □ |
| Does child use floss every day? | □ | □ |
| Has child had any unhappy dental experiences? | □ | □ |
| Any mouth habits (thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle) | □ | □ |

**Minor/ Child's Physician**_____ City/State_____ Phone (___) _____
Date of last physical examination: _____ Result: _____

| | YES | NO |
|---|---|---|
| Is Minor/ Child under care of physician now? | ☐ | ☐ |
| Medications_____ | | |
| Receiving any medication or drugs? | ☐ | ☐ |
| Please list if applicable: _____ | | |
| Ever been hospitalized? | ☐ | ☐ |
| Ever had surgery? | ☐ | ☐ |
| Allergies: _____ | | |
| Is there excessive bleeding when cut? | ☐ | ☐ |

Has minor/ child had any history of or difficulty with any of the following? If yes, please check

| | | | |
|---|---|---|---|
| ☐ A.I.D.S./ H.I.V | ☐ Cerebral Palsy | ☐ Epilepsy | ☐ Kidney Disease |
| ☐ Anemia | ☐ Chicken Pox | ☐ Fainting | ☐ Liver Disease |
| ☐ Asthma | ☐ Convulsions | ☐ Hearing Problems | ☐ Measles |
| ☐ Bladder Problems | ☐ Diabetes | ☐ Heart Problems | ☐ Mononucleosis |
| ☐ Cancer | ☐ Head injuries | ☐ Hepatitis | ☐ Mumps |
| ☐ Rheumatic Fever | ☐ Sinus Problems | ☐ Thyroid Disease | ☐ Tuberculosis |
| ☐ Autism spectrum | ☐ Stroke | ☐ Other: _____ | |

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone (___) _____

Name_____ Relationship_____ Phone (___) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

**Minor/Child Consent**

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

And there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

**Insurance Assignment and Release**

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

And assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. I authorize Dr. Pourasaeid and her staff to submit claims or otherwise communicate with my dental insurance electronically. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ Date _____
Signature of Parent, Guardian or Personal Representative

_____ Date _____
Dentist Signature