PATIENT INFORMATION

Furnishing the following information would be appreciated as these questions are of great value in understanding, diagnosing and treating your child.

Child's name_____ **Your child likes to be called**_____
First Middle Last
Age_____ **years Date of Birth: Month**_____ **Day** _____ **Year**_____ **M ( ) F ( ) Child's SSN:** _____-____-_____

Address: _____ _____ **City**_____ **ST** _____ **Zip** _____

Phone #: _____ **Grade Level** _____ **Patient's School** _____

Patient's hobbies, interests, pets: _____
Other Children and their ages: _____

Whom may we thank for referring you to this office? _____

Is anyone other than the custodial parent(s) authorized to bring the child for care and treatment? If so, please list each such person. _____

Father's Name _____
Date of Birth_____
Employer _____
Occupation _____
Work Phone _____
Cell Phone_____
***Social Security #** _____-_____-_____
Email _____

Mother's Name _____
Date of Birth_____
Employer _____
Occupation _____
Work Phone_____
Cell Phone _____
***Social Security #** _____-_____-_____
Email_____

Name of parent's nearest relative (not living with you) _____

Do mother, father, and child live together? _____ **Yes** _____ **No If no, with whom does the child live?** _____
If parents do not live together, please provide other parents information.

Name _____**Cell Phone** _____ **Home Phone**_____
Street Address _____ **Apt.** _____**City** _____ **St**_____ **Zip**_____
***SSN** _____-_____-_____ **Relation to child**_____ **Date of birth**_____
Employment position/Title _____ **Work Phone**_____
Company Name _____

Is child insured? _____ **Yes** _____**No Policy Holder** _____ **Policy holders DOB**_____

Ins Co_____ **Ins co phone #**_____ **Id#**_____ **Group #**_____

Social Security #_____ **Employer**_____ **Relationship to child**_____

As a courtesy for our patients with insurance, our office will file your insurance claims. Insurance plans do not cover the full cost of dental services and the patient is responsible for their co-pay portion. We request insurance co-pays for professional services rendered at the time of treatment, as well as any deductibles that have not been met. Regardless of the status of an insurance claim, full payment is due to our office within sixty (60) days from the date of service.

MEDICAL HISTORY:

Child's physician or pediatrician _____ **Phone** _____
Date of last physical exam _____**Where?** _____

YES	NO	
( )	( )	**1. IS YOUR CHILD IN GOOD HEALTH?**
( )	( )	**2. IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN FOR OTHER THAN ROUTINE CARE? If YES, PLEASE EXPLAIN.** _____
( )	( )	**3. DOES YOUR CHILD HAVE ANY DRUG ALLERGIES?** _____
( )	( )	**4. IS YOUR CHILD TAKING ANY MEDICATIONS AT THIS TIME? IF YES, PLEASE LIST** _____
( )	( )	**5. HAS YOUR CHILD EVER BEEN HOSPITALIZED OR TREATED IN AN EMERGENCY ROOM?** _____ **WHEN AND FOR WHAT REASON?** _____ _____
( )	( )	**6. DOES YOUR CHILD HAVE, OR HAS HE OR SHE HAD, ANY EMOTIONAL, MENTAL OR NERVOUS DISORDERS? IF YES, PLEASE EXPLAIN** _____
( )	( )	**7. HAVE YOUR CHILD'S TONSILS AND/OR ADENOIDS BEEN REMOVED? WHEN?** _____
( )	( )	**8. DOES YOUR CHILD BREATHE THROUGH THE MOUTH? IF YES, ( ) SELDOM ( ) OFTEN**

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

_____Allergy to Penicillin	_____HIV	_____Cleft palate
_____Other drug allergy	_____Diabetes	_____Asthma / Inhaler use
_____Radiation Treatment	_____Epilepsy, Seizures	_____Allergies to food, grasses, pollen
_____Anemia	_____Bleeding disorder	_____Liver problems or hepatitis
_____Rheumatic fever	_____Tuberculosis	_____Malignancies or leukemia
_____Bone disorder	_____Endocrine disorder	_____Speech problem
_____Mental handicap	_____Physical handicap	_____Chronic sinus problems

_____Heart Ailment or Murmur. Type, if known _____ Is child under the care of a cardiologist or special physician for the problem? If so, whom _____

Please comment on any problems that were checked in the above areas: _____
_____

Do you consider your child to be _____Advanced _____Progressing normally _____A slow learner

DENTAL HISTORY:

YES NO

( ) ( ) Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child? _____

( ) ( ) Do you expect your child to be a cooperative patient? If no, please explain_____
_____

( ) ( ) Does your child take fluoride tablets or drops with vitamins with fluoride? _____

( ) ( ) Has your child bumped mouth or any teeth? If so, when _____
What happened? _____

( ) ( ) Has your child a history of headaches, pain, popping or clicking of the jaw? _____

( ) ( ) Does your child still have a night time bottle? _____

( ) ( ) Does your child have a toothache? _____When did it begin?_____

( ) ( ) Does your child have or has he or she had any of the following problems or habits?

_____Thumb sucking How long? _____ Still active? ( ) YES ( ) NO
_____Finger habit How long? _____ Still active? ( ) YES ( ) NO
_____Pacifier How long? _____ Still active? ( ) YES ( ) NO

Does your child have any other mouth habits? _____
At what age did your child stop using a nursing bottle? _____
How often are your child's teeth brushed? _____
Who brushes your child's teeth? _____
What type of toothpaste does your child use? _____
Does your family drink well or city water? _____
What is the reason for this visit? _____
Has your child ever had an unpleasant dental or medical experience? _____
_____
Has your child ever had a reaction to dental anesthetic? _____
Does your child have a dental problem about which you are especially concerned? (If yes, what is the problem?)_____

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*Social security numbers are required if we are filing insurance for your child. Insurance uses them as an identifier when we check benefits.

The undersigned represent that the responses to the foregoing information requests are true, correct and complete and expressly understood and I as the responsible party agree to the following: that the information will be used in the treatment of the minor child and that its accuracy and completeness are essential to safe and effective treatment; that the financial information is correct and is relied upon in the decision to commence treatment; that is has been explained that payment is expected at the time of treatment; that all accounts thirty days past due will bear interest at the rate of one and one-half percent (1 ½%) per month; that if collection of past due account becomes necessary that 15% attorney's fees shall be collected in addition to the accrued fees, interest, and cost; and that each parent or guardian and in particular the parent or guardian who brings the child for treatment shall be responsible for payment and to advise the staff of any change(s) in the health or medical or physical condition of the child and any other factors which may impact upon the treatment for the child, in addition to insurance coverage changes (we have a limited number of days to file claims for you), including financial responsibility.

The undersigned hereby authorizes Dr. Rhea M. Haugseth and her staff to treat this patient for routine and necessary dental procedures using diagnostic, restorative and patient management techniques that are generally accepted and proper and I further authorize and consent that Dr. Haugseth choose and employ such assistants and technicians as she shall deem necessary in her professional judgment. As a condition of treating the child by Dr. Haugseth, the undersigned promises to pay all reasonable costs, and fees, together with interest at the rate of 1 ½ % balances over (30) days old, and if collection must be made by law, 15% attorney's fees of the account balance, including interest, fees, costs, and expenses. Payment is expected at the time services are rendered, unless prior financial arrangements have been made.

Date _____

Mother's Signature _____

Father's Signature _____

Guardian's Signature _____