TLC DENTISTRY, P.S.C.

We would like to say thank you for selecting our dental team! So that we may better serve you, please provide or update this information for us. This practice is HIPPA compliant and all information is secured for treatment and insurance purpose only. Your thoroughness is greatly appreciated.

Child's Information

Your Child: ______________________________ Date: __________
Last, First MI (Preferred Name)

Gender: ______________________________ Family Status __________

Child's Social Security #: ______________ Birth Date: ______________

Phone (Home): __________ School: ______________ Grade: __________

Child's Home Address: ______________________________
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Cleaning: __________ Reason for that visit: ______________

Has your child ever had any of the following? Please check those that apply:

MEDICAL HISTORY

- ☐ Allergies __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Eye Disorders
- ☐ Handicaps/ Disabilities
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disorders

DRUG ALLERGIES

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Drug Allergies

DENTAL HISTORY

- ☐ Bad Breath
- ☐ Bite/ Chew Nails
- ☐ Biteguard Therapy
- ☐ Bleeding Gums
- ☐ Bleaching Treatment
- ☐ Blisters/ Sores on Lips
- ☐ Clench/ Grind Teeth
- ☐ Mouth Breathing
- ☐ Severe Gag Reflex
- ☐ Suck/ Bite Lip
- ☐ Suck Thumb/ Finger
- ☐ Wisdom Teeth removed

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Is your child under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: __________

  ☐ Prescribed Medications: ______________________________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Has your child had orthodontic treatment? __________ If so when ______________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other __________

Name of person or office referring you to our practice:

Parent or Responsible Party Information

The following is: ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Guardian

Name: ______________________________

☐ Male ☐ Female

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: ______________

Address: ______________________________ Cell Phone (optional) ______________

Street Apartment #

____

City State Zip Code E-MAIL ADDRESS

Responsible Party
Employer Name: ____________________ Occupation: ____________________

Address: ______________________________

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ______________________________

Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

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Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

______________________________ Date: __________ Relationship to Patient: ______________

Signature of parent or guardian