Please remember you are financially responsible for your account, regardless of your insurance coverage.

OCEANVIEW DENTAL CHILD PATIENT INFORMATION

This information is important for our records as well as your child's health care and will be kept confidential

Date _____ Purpose of visit _____

Is child experiencing any pain? **YES NO** If yes, duration and location _____

Who may we thank for referring you to our office? _____

PATIENT FIRST NAME _____ **LAST NAME** _____ **M / F Birthdate**_____

Home address _____City _____ State _____Zip _____

Mother's First Name_____ Last Name_____ SS#_____

Home phone _____ Cell phone _____Email _____

Father's First Name_____ Last Name_____ SS#_____

Home phone _____ Cell phone _____Email _____

Is child covered by dental benefits? **YES NO If yes, please complete a dental insurance information questionnaire.**

MEDICAL HISTORY_____

Name of Primary Care Doctor _____City _____ Phone _____

YES NO Has the child been under the care of a physician during the past 2 years, besides for routine check-ups?
If yes, please describe reason_____

YES NO Is your child in relatively good health?
YES NO Does your child need to be pre-medicated prior to dental treatment? **Please explain**_____
YES NO Is child subject to nervous disorders, fainting or dizziness? **Please explain**_____
YES NO Does child have history of heart trouble? **Please explain**_____
YES NO Has child ever experienced any ill effect from Novocaine or any other dental drug? **Type?**_____

YES	**NO**	History of rheumatic fever?	**YES**	**NO**	Human Immunodeficiency Virus (HIV)
YES	**NO**	History of Hepatitis?	**YES**	**NO**	Does child have seasonal allergies?
YES	**NO**	Is child subject to prolonged bleeding?	**YES**	**NO**	History of epilepsy?
YES	**NO**	Diabetes?	**YES**	**NO**	Asthma?
YES	**NO**	Liver or kidney involvement?	**YES**	**NO**	Tuberculosis?
YES	**NO**	Allergic to Penicillin?	**YES**	**NO**	Any other allergy?_____
YES	**NO**	Human Papillomavirus (HPV)			

HEALTH HISTORY UPDATE_____

DATE	CHANGE	INITIALS

DENTAL HISTORY_____

Is this the child's first visit? **YES** **NO** If NO, Name of previous dentist_____
Date of last visit_____What was done at that time?_____

Are you dissatisfied with your child's teeth or their appearance? **YES** **NO**
If YES, what concerns you the most?_____

Has child experienced an unfavorable reaction to any previous dental treatment? **YES** **NO**
If YES, what occurred?_____

Has child had any speech correction? **YES** **NO**

Does child have any of the following habits?	Thumb sucking	**YES**	**NO**	Grinding or clenching of teeth	**YES**	**NO**
	Mouth-breathing	**YES**	**NO**	Lip or nail biting	**YES**	**NO**

Have there been any serious injuries to the face, head or teeth? **YES** **NO**
If YES, nature and location of injury_____

PLEASE INQUIRE ABOUT ANY ABOVE QUESTIONS WHICH ARE NOT UNDERSTOOD

CONSENT OF TREATMENT

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge.

Parent/Guardian Name_____Date_____

RESPONSIBLITY FOR FEES AND ASSIGNMENT OF INSURANCE BENEFITS: I understand the responsibility for payment for Dental Services provided in this office for my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on date which services are provided. I hereby authorize payment from any insurance company be paid directly to this office. In the event of default in payment, the party responsible for fees agrees to pay all costs of suit, collection and/or attorney's fees. **24 HOUR CANCELLATION NOTICE PREVENTS $75 BROKEN APPOINTMNET FEE.**

Responsible party signature_____Date_____