Simsbury Pediatric and Adolescent Dentistry, L.L.C.

Tell Us About Your Child

Today's Date: ________ Child's Name: ________________________ Nickname: ____________

Male / Female   Child's Birthdate: _____________ Child's Age: _________ Grade: __________

Name of School: ____

Who Is Accompanying The Child Today?

Name: ____ Relation: ______________________

Do you have legal custody of the child? **Yes / No**

Has your child ever had any of following medical problems? ***Circle below Y or N***

Y - N ***Heart Murmur***
Y - N ***Rheumatic Fever***
Y - N ***Artificial Heart Valves***
Y - N ***Congenital Heart defect***
Y N ***Scarlet Fever***
Y - N ***Surgeries/Operations***
Y - N ***Cancer/Tumors***
Y - N ***Chemotherapy***
Y - N ***Jaw Problems TMJ/ TMD***
Y - N ***Tonsillitis***
Y - N ***Respiratory Problems***
Y - N ***Asthma/Difficulty breathing***
Y - N ***Blood Transfusion(s)***
Y - N ***Leukemia***
Y - N ***Anemia***
Y - N ***Diabetes/Hypoglycemia***
Y - N ***Hemophilia***
Y-N ***Abnormal Bleeding***
Y - N ***High/Low Blood Pressure***
Y - N ***Hepatitis***
Y - N ***Artificial Bones/Joints/Implants***
Y - N ***Organ Problems***
Y - N ***HIV+/AIDS/ARC***
Y - N ***Tuberculosis TB***
Y - N ***Psychiatric Problems***
Y - N ***Hyper Active /ADD***
Y - N ***Fainting/Seizures/Epilepsy***

Other medical conditions or concerns not listed: ____________________________________

____

Please list any allergies: ____

____

Child's physician: _______________________________ **Phone#** __________________

Date of Last Visit: ______ Please describe the child's current physical health- **Good /Fair /Poor**. Please list all medications that your child is currently taking: ____

We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ___________________________ Date: _______ Reviewed by: ______________
Parent /Guardian

Signature: ___________________________ Date: _______ Reviewed by: ______________
Parent /Guardian

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UPDATE ACCOUNT INFORMATION

Do you have dental insurance? Please circle- YES or NO

Insurance subscriber's name: ____

* **name of person holding the insurance coverage**

Subscriber's date of birth: _____/_____/_____ Soc. Sec#________-________-________

Subscriber's relationship to child:____

Phone: H=____________________W=____________________C=________________

Home address: ___________________________City:____________________

State: ___________ Zip Code: _________Employer:__________________________

Employer Address: ____

E-MAIL ____________________________@____________________________

Primary Dental Ins. Co. ____________________	**Secondary Dental Ins.Co**. ____________________
Ins Address: _______________________	**Ins. Address**________________________
City____________ST.______Zip_______	**City__________ST.______Zip_______**
	Subscriber __________________________
Subscriber ID#_____________________	Subscriber ID#_________________________
	Group #_____________ DOB___________
Group #___________________________	**Soc. Sec#** _________-_________-________

Children's Name: ____

Please list person's name and relationship to your child that would accompany them to this office for treatment and have your permission to do so:

Name________________________________Relationship_______________________

Name________________________________Relationship_______________________

Signature of parent or guardian: __________________________________ Date ________

Note: We reserve the right to charge a $50 fee for last minute cancellations or failure to show for scheduled appointments.