WELCOME!

Tell Us About Your Child

Today's Date: ____________________

Child's Name: ______________________________ Child's Birth date: ____________________

Child's nickname (if applicable) ______________________________ ☐ Male ☐ Female Age: __________

Child's Address: ____
Street City State zip

How did you hear about our office? ____

Are any siblings patients here? ____

Parent Information

Mother's Name: ____________________ Social Security #: __________ Birth Date: __________

Address: (if different from child's) ____

Home Phone #: ______________ Work #: ______________ Cell Phone: ______________

Employer: ______________________________ Occupation: ______________________________

E-Mail address ______________________________

Father's Name: ____________________ Social Security #: __________ Birth Date: __________

Address: (if different from child's) ____

Home Phone #: (if different) ______________ Work #: ______________ Cell Phone: ______________

Employer: ______________________________ Occupation: ______________________________

E-Mail address ______________________________

Dental Insurance Information

Primary Insurance (if insured by other than parent, let us know so we can obtain all necessary information)

Name of Policy Holder: ______________________________ Relationship to patient: ______________

Insurance Co. Name: ______________________________ Group # (plan, local or policy #): ______________

Insurance Co. Address: ______________________________ Insurance phone #: ______________

Secondary Insurance

Name of Policy Holder: ______________________________ Relationship to patient: ______________

Insurance Co. Name: ______________________________ Group # (plan, local or policy #): ______________

Insurance Co. Address: ______________________________ Insurance phone #: ______________

(OVER)

Medical History

Has your child experienced any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Bleeding	☐	☐	Handicaps/disabilities	☐	☐	Latex allergy
☐	☐	Aids/HIV+	☐	☐	Hearing impairment	☐	☐	Liver problems
☐	☐	Allergies to medications	☐	☐	Heart defect	☐	☐	Measles
☐	☐	Autism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Rheumatic fever
☐	☐	Blood transfusion	☐	☐	Hepatitis	☐	☐	Sickle cell anemia
☐	☐	Cancer	☐	☐	High blood pressure	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Hospitalizations	☐	☐	Other ____________
☐	☐	Epilepsy or seizures	☐	☐	Kidney problems			____________

Please describe more fully any boxes checked above: ____

____

Is your child currently under the care of a physician? ____

Child's physician and phone #: ____

Please list all medications your child is taking: ____

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Dental History

What is the reason for today's visit? ____

Previous dentist and phone #: ____

Privacy Notice

I understand that every effort will be made by Dr. Babot or Dr. Fuselier and their staff to ensure the privacy of my records. I understand that if I need special treatment regarding my privacy such as not using certain addresses and phone numbers I have listed, that I need to inform Dr. Babot or Dr. Fuselier in writing of such requests. I also will request, if I am interested, a more thorough copy of my privacy rights from the receptionist.

____

Signature Date

Authorization

I affirm that the information given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform routine services that my child may need including cleanings, x-rays and topical fluoride applications. I assign all insurance benefits to Dr. Babot or Dr. Fuselier. I understand that I am responsible for payment of services rendered. I understand that Dr. Babot or Dr. Fuselier will file my insurance claims as a courtesy to me, but that I am ultimately responsible for ensuring that the dental services are paid.

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Signature Date