



ABOUT YOUR CHILD

CHILD'S FULL NAME _____

NAME CHILD PREFERS TO BE CALLED _____

AGE M F _____ DATE OF BIRTH _____

WEIGHT _____ HEIGHT _____

REASON FOR VISIT _____

REFERRED BY _____ FULL NAME _____

PHONE # _____

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT YES NO

PREVIOUS DENTIST _____ CITY _____

DATE OF LAST VISIT _____

ANY INJURIES TO YOUR CHILD'S TEETH, JAWS, HEAD OR NECK? YES NO
WHEN? _____

HISTORY OF: _____ WHEN? _____

- Nursing bottle habits _____
- Thumb/finger/lip habits _____
- Pacifier _____
- Recent dental pain _____
- Previous dental treatment _____

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?

YES NO (Please explain)

PLEASE RELATE ANY INFORMATION THAT WILL HELP US UNDERSTAND YOUR CHILD

MEDICAL HISTORY

CHILD'S PHYSICIAN/PEDIATRICIAN _____ PHONE # _____

• Does your child have a history of health problems or any illnesses? Yes No
Please explain: _____

• Is your child presently under the care of his/her physician for any medical reason? Yes No
Please explain: _____

• Is your child presently under the care of a specialist for any medical reason? Yes No
Please explain: _____

SPECIALIST'S NAME _____ PHONE # _____

• Are antibiotics necessary for dental treatment because of heart murmur, heart defect, prosthesis, shunt or other medical reason? Yes No

• Is your child presently taking any medications? Yes No
What? _____

• Has your child had a history of taking medications frequently? Which ones? _____ Yes No

• Has your child ever been hospitalized or had surgery including same-day surgery? Yes No
For what _____

• Is your child allergic to any drugs/medicines? Yes No

• Has your child ever had any adverse reactions to any medications, drugs, or latex? Yes No
If yes, what? _____

• Has your child or any member of his/her family ever had a problem with a general anesthetic? Yes No
Please explain: _____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? CHECK YES OR NO:

- | Y | N | | Y | N |
|--------------------------|--------------------------|-----------------------------------------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder conditions | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone or Joint Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruising Easily | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or Malignancies | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy/Radiation | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Adenoid/
Tonsil Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental Delay | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Addictions | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Disturbance | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Gagging | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Growth /Development Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing/Speech Impediment | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur/Defect | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperactivity/ADD | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Disability | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth Sores | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring/MouthBreathing Syndrome _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wish to talk to the doctor privately about a special concern ? | <input type="checkbox"/> | <input type="checkbox"/> |

We accept any Insurance that gives you freedom of choice but we are not a PPO provider for any dental insurance. You may have some out of pocket expense as every plan is negotiated differently with your employer.

We will bill your insurance as a courtesy. However, we can only provide you with an Estimate based on your benefit plan. It is understood that you are responsible for the entire balance regardless of your insurance coverage. Please understand that the contract for dental insurance is between you, the patient, and your Insurance company. Therefore, any dispute of coverage is between you and your dental insurance company.

INSURANCE INFORMATION

INSURED'S NAME _____ DOB _____

ADDRESS/PHONE (IF DIFFERENT) _____

PRIMARY INSURANCE ADDRESS _____

GROUP # _____ POLICY # _____

DUAL COVERAGE? YES NO

SECONDARY INSURANCE ADDRESS _____

GROUP # _____ POLICY # _____

RESPONSIBLE PARTY FATHER/MOTHER

FATHER'S FULL NAME (OR LEGAL GUARDIAN) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ BIRTH DATE _____ E-mail _____

HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____

OCCUPATION _____ EMPLOYER _____ E-MAIL _____

MOTHER'S FULL NAME (OR LEGAL GUARDIAN) _____

ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ BIRTH DATE _____

HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____

OCCUPATION _____ EMPLOYER _____

PARENTS ARE:

Married Single Divorced Separated Legal Guardian

THE PERMISSION OF THE PARENT OR LEGAL GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.

I give doctor Surillo permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic and/or unusual reactions to drugs, food, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me.

• I hereby certify the foregoing information is true and correct. _____
 SIGNATURE _____ DATE _____
 RELATIONSHIP _____

• I authorize release of any information relating to this claim.
 I understand that I am responsible for all costs of dental treatment.

 SIGNED (PATIENT OR PARENT OF MINOR)

• I hereby authorize payment to the above named dentist of the group insurance benefits otherwise payable to me. _____
 SIGNED (INSURED PERSON)