RUSHMORE DENTAL

TELL US ABOUT YOUR CHILD

Todays date:_____Child's name:_____Nickname:_____

Child's birthdate:_____Child's age_____Grade_____School:_____

SS#_____Child's home address_____

Child's home address:_____Email:_____

WHO IS ACCOMPANING THE CHILD TODAY?

Name:_____Relation:_____

Do you have legal custody of this child? **Y / N** Is child adopted? **Y / N**

Is child in a foster home? **Y / N** Other siblings seen by us:_____

Previous/present dentist:_____Last visit:_____

Parent's marital status: **Married Single Divorced Partnered Separated Widowed**

PARENT'S INFORMATION

MOTHER Stepmother Guardian Birthdate:_____

Work phone:_____Home phone:_____

Employer:_____Employer address:_____

SS#_____DL#_____

FATHER Stepfather Guardian Birthdate:_____

Work phone:_____Home phone:_____

Employer:_____Employer address:_____

SS#_____DL#_____

Neighbor or relative not living with you

His/Her name:_____Relation:_____

Work phone:_____Home phone:_____

Home address:_____City/State/Zip:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____Relation:_____

Billing Address:_____City/State/Zip_____

Work phone:_____Home phone:_____

SS#_____Birthdate:_____DL#_____

Who is responsible for making appointments? Name:_____Relation:_____

Work phone:_____Home phone:_____

Insurance Information

Primary Insurance co. name:_____

Insurance co. address:_____Insurance co. phone:_____

Group#(Plan, Local, or Policy#):_____Policy owner's birthdate:_____

Policy owner's name:_____Relation:_____

Policy owner's employer:_____Orthodontic coverage **Y / N**

Employer's address:_____

Secondary Insurance co. name:_____

Insurance co. address:_____Insurance co. phone:_____

Group#(Plan, Local, or Policy#):_____Policy owner's birthdate:_____

Policy owner's name:_____Relation:_____

Policy owner's employer:_____Orthodontic coverage **Y / N**

Employer's address:_____

Dental/Medical History

Why did you bring your child to the dentist today?_____

Has the child ever had a serious/ difficult problem associated with any dental work? **Y / N**

Is the child's water fluorinated? **Y / N** Is the child taking fluoridated supplements? **Y / N**

Has the child ever experienced pain/ discomfort in their jaw joint (TMJ/TMD)? **Y / N**

Does the child brush his/her teeth daily? **Y/N** Does the child floss his/her teeth daily? **Y/N**

Child's physician:_____Phone:_____Date of last visit:_____

Is the child currently under the care of a physician? **Y / N** If yes, why:_____

Describe the child's physical health: **GOOD FAIR POOR**

Has this child ever taken Phen-Fen: **Y / N** If yes, when?_____

Please list all drugs that the child is currently taking:_____

Aside from items listed below, list all drugs/things the child is allergic to :

_____

Latex **Y / N** Metals/nickel **Y / N** Plastics **Y / N**

Has the child ever had any of the following medical problems?

Y / N	Abnormal bleeding	**Y / N**	Convulsions	**Y / N**	Hives
Y / N	ADD/ADHD	**Y / N**	Diabetes	**Y / N**	HIV/AIDS
Y / N	Anemia	**Y / N**	Epilepsy	**Y / N**	Kidney/liver problems
Y / N	Any hospital stays	**Y / N**	Handicaps/disabilities	**Y / N**	Measles
Y / N	Any operations	**Y / N**	Hearing Impairment	**Y / N**	Mononucleosis
Y / N	Artificial bones/joints/valves	**Y / N**	Heart Murmur	**Y / N**	Rheumatic/Scarlet fever
Y / N	Asthma	**Y / N**	Hemophilia	**Y / N**	Skin Rash
Y / N	Cancer	**Y / N**	Hepatitis	**Y / N**	Sickle Cell disease
Y / N	Chicken Pox	**Y / N**	Exposed to HIV, but negative		
Y / N	Congenital Heart Defect	**Y / N**	Tuberculosis (TB)		

Does/ did the child have any of the following habits?

Lip sucking/ biting **Y / N** Nursing bottle habits **Y / N** Nail biting **Y / N**

Thumb/finger sucking **Y / N** Was the child breast fed **Y / N**

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandates by OSHA, the CDC and the ADA

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

My method of payment will be:_____

_____

Signature of parent or guardian Date

I certify that my child is covered by_____Insurance Co. and I assign directly to Dr._____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____

Signature Date