CHILD GET ACQUAINTED QUESTIONNAIRE

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	SEX:

STREET ADDRESS:	CITY, STATE:	ZIP CODE:

PARENT/GUARDIAN:	HOME PHONE:	DAY TIME PHONE:
PARENT TO CONTACT REGARDING TREATMENT:	HOME PHONE:	DAY TIME PHONE:

I WOULD LIKE APPOINTMENTS TO BE CONFIRMED AT ☐ HOME PHONE ☐ DAYTIME PHONE ☐ EMAIL ___________________________________	WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT:	RELATIONSHIP TO PATIENT:

BILLING ADDRESS:	CITY, STATE:	ZIP CODE:

EMPLOYER: PHONE:	HOME PHONE:	CELL PHONE:

SS#:	DATE OF BIRTH:	I WOULD LIKE STATEMENTS TO BE SENT VIA ☐ POST OFFICE ☐ EMAIL ______________________________

INSURANCE INFORMATION

PRIMARY CARRIER	SECONDARY CARRIER
INSURANCE COMPANY:	INSURANCE COMPANY:
ADDRESS: CITY: STATE: ZIP CODE:	ADDRESS: CITY: STATE: ZIP COPE:
SUBSCRIBER: SS#: DOB:	SUBSCRIBER: SS#: DOB:
RELALTIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER:
GROUP, PLAN, LOCAL OR POLICY #:	GROUP, PLAN, LOCAL OR POLICY #:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

SIGNATURE: DATE:	SIGNATURE: DATE:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNATURE: DATE:	SIGNATURE: DATE:

DENTAL HISTORY FOR CHILDREN

1. WHAT IS THE MOST COMMON REASON YOU TAKE YOUR CHILD TO THE DENTIST?

   ____

2. DOES YOUR CHILD HAVE ANY TEETH THAT NEED ATTENTION NOW?

   ____

3. WHAT KIND OF HOME CARE INSTRUCTIONS HAS YOUR CHILD BEEN GIVEN?

   ____

4. WHAT DO YOU KNOW ABOUT PLAQUE?

   ____

5. DOES YOUR CHILD CLENCH OR GRIND HIS/HER TEETH AT NIGHT? ______________
6. DOES YOUR CHILD'S GUMS BLEED WHEN CLEANING HIS/HER MOUTH? ______________
7. HAS YOUR CHILD HAD DISCOMFORT OR PROBLEMS WITH PAST TREATMENT?

   ____

8. HAS YOUR CHILD HAD NITROUS OXIDE SEDATION BEFORE?

   ____

9. DO YOU HAVE ANY PLANS FOR YOUR CHILD'S DENTAL FUTURE?

   ____

10. HAS YOUR CHILD HAD A LOCAL ANESTHETIC LIKE NOVACAINE? ______________
11. HAS YOUR CHILD HAD AN UNFAVORABLE REACTION FROM A LOCAL ANESTHETIC? IF SO, PLEASE EXPLAIN.

    ____

    ____

12. HOW LONG SINCE YOUR CHILD'S LAST DENTAL TREATMENT? ______________
13. HOW LONG SINCE YOUR CHILD'S LAST FULL MOUTH X-RAYS? ______________
14. IS YOUR CHILD TAKING FLUORIDE SUPPLEMENTS? ______________