McGUFFEY
BEAR | TOOTH | DENTAL | P.C.

# •WELCOME•

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions about this form, please ask and we will be happy to help.

## Child Information (Confidential)

Child's Last Name_____ First Name_____ M.I.____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Home Phone(_____)_____ DOB_____/_____/_____ Sex M F

Person to contact in case of emergency_____ Phone Number(____)_____

Which payment method do you prefer? Cash_____ Check_____ Visa/MasterCard_____

How did you hear about our office?_____

## Parent/Guardian Information

Father_____ Stepfather_____ Guardian_____

Last Name_____ First Name_____ M.I.____

Address (If Different)_____ City_____ State_____ Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

SSN_____-_____-_____ DOB_____/_____/_____ Employer_____

Mother_____ Stepmother_____ Guardian_____

Last Name_____ First Name_____ M.I.____

Address (If Different)_____ City_____ State_____ Zip_____

Home Phone(_____)_____ Work Phone(_____)_____ Cell Phone(_____)_____

SSN_____-_____-_____ DOB_____/_____/_____ Employer_____

## Primary Insurance Information

Name of Insured_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

**Does the child have secondary insurance? Yes_____ No_____**

2nd Insured's Name_____ Relationship to Patient_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Group #_____ Phone #_____

# Child Dental History

Reason for today's visit_____Previous Dentist_____

Is this your child's first visit to the dentist: Yes_____ No_____ If no, date of last dental x-rays/visit_____/_____

Please share with us any concerns you may have with regards to your child's teeth:_____

_____

**Please circle below if your child has or has had any of the following problems or habits:**

| | | | |
|---|---|---|---|
| Cavities | Toothache | Bad Breath | Loose Teeth |
| Crooked Teeth | Sensitive to sweets | Bleeding gums | Teeth Bumped |
| Sensitive to hot or cold | Frequent headaches | Discolored teeth | Thumb Sucking |
| Pacifier Use | Teeth Grinding | Other_____ | |

# Child Medical History

**Physician**_____ **Date of Last Exam**_____/_____

1. Is the child under medical treatment now? Yes_____ No_____

   If yes, please explain_____

2. Has the child ever been hospitalized for any surgical operation or serious illness within the last 2 years? Yes_____ No_____

   If yes, please explain_____

3. Is the child currently taking any medication(s) including non-prescription medicine? Yes_____ No_____

   If yes, please explain_____

4. Is the child allergic to or has the child had any reactions to the following?

| | | |
|---|---|---|
| Local Anesthetics (ex. Lidocaine) | Yes____ | No____ |
| Penicillin or any other antibiotics | Yes____ | No____ |
| Sulfa Drugs | Yes____ | No____ |
| Barbiturates | Yes____ | No____ |
| Sedatives | Yes____ | No____ |
| Iodine | Yes____ | No____ |
| Aspirin | Yes____ | No____ |
| Any Metals (ex. Nickel, mercury etc.) | Yes____ | No____ |
| Latex Rubber | Yes____ | No____ |

Other_____

5. Is the child taking any blood thinners? Yes____ No____
6. Is the child in good general health? Yes_____ No_____

   If no, please describe_____

   _____
7. How does your child tolerate dental care?_____

   _____

**Please circle if the child currently has or has had any of the following:**

| | | | |
|---|---|---|---|
| ANEMIA | DIABETES | HEPATITS | RADIATION THERAPY |
| ANGINA | DIZZINESS | HIGH/LOW BLOOD PRESSURE | RECENT WEIGHT LOSS |
| ARTHRITIS | EPILEPSY/CONVULSIONS | JOINT REPLACEMENT/IMPLANT | RESPIRATORY PROBLEMS |
| ASTHMA | EMPHYSEMA | KIDNEY DISEASE | RHEUMATIC FEVER |
| AUTOIMMUNE DISEASE | EXCESSIVE BLEEDING | LIVER DISEASE | SINUS PROBLEMS |
| AIDS/HIV INFECTION | FAINTING/SEIZURES | LEUKEMIA | STOMACH PROBLEMS/ULCER |
| BLOOD DISEASE | HEAD INJURIES | MENTAL DISORDER | STROKE |
| CANCER | HEART DISEASE/ATTACK | MITRAL VALVE PROLAPSE | THYROID PROBLEMS |
| CHEMOTHERAPY | HEART MURMUR | NERVOUS DISORDER | TUBERCULOSIS |
| | | | OTHER_____ |

# Authorization & Release/Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

a. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
b. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
c. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Parent/Guardian Signature_____ Date_____/_____/_____