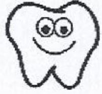
Welcome



Patient Information

Today's Date ____________________

Child's ______________________________ Nickname ______________ Sex ________
First Name Last Name MI

Date of Birth ______________ Age ______ Social Security : ____________________

Address __________________________ City ________________ Zip __________

Phone ( ) ____________ School ______________________ Grade __________

Whom May We Thank For Referring You? ______________________________________

Mother/Guardian

□ Mother □ Guardian □ Step-mother

□ Married □ Single □ Divorced □ Other

Name ______________________ DOB __________

Address(if different from patient's) ______________________________

City ________________ State ______ ZIP ________

Home Phone ( ) __________ Work Phone( ) __________

Cell Phone ( ) ______________ Soc. Sec. ____________

Employer ______________________________________

Email: ______________________________________

Father/Guardian

□ Father □ Guardian □ Step-father

□ Married □ Single □ Divorced □ Other

Name ______________________ DOB __________

Address(if different from patient's) ______________________________

City ________________ State ______ ZIP ________

Home Phone ( ) __________ Work Phone( ) __________

Cell Phone ( ) ______________ Soc. Sec. ____________

Employer ______________________________________

Email: ______________________________________

Nearest Relative

(not living with you)

Relationship ______________________________________

Name ______________________________________

Address ______________________________________

City ________________ State ________ Zip ________

Home Phone ______________ Cell Phone ______________

All about your Child:

Favorites:

Sport ________________ Toy ________________

Fiction Character ______________________________

Siblings Names & Ages ______________________________

____

Dental History

	YES	NO
Date of last visit to a dentist ________________ For what service ________________		
Any injuries to mouth/teeth/head? Describe ________________	□	□
Any mouth habits (thumb-sucking, mouth breathing, nursing, pacifier, etc.? ________	□	□
Orthodontic appliances worn now or ever worn?	□	□
Any unusual speech habits?	□	□
Does your child brush his/her teeth daily?	□	□
Do you assist your child with tooth brushing?	□	□
Has your child complained about dental problems? Describe ________________	□	□
Does your child drink fluoridated water?	□	□
Is any other fluoride taken?	□	□
Do you desire complete dental services for your child?	□	□
Child's attitude towards dentistry ____________		

OVER PLEASE

Primary Dental Insurance

(please give copy of ins card to receptionist)

Insured's Name________________________

Relationship______________ Birthdate__________

Employer______________ Occupation__________

Social Security #:______________ Group#:__________

Insurance Co: ________________________

Ins. Co. Address________________________

City ______________ State______ Zip __________

Secondary Dental Insurance

(please give copy of ins. card to receptionist)

Insured's Name________________________

Relationship______________ Birthdate__________

Employer______________ Occupation__________

Social Security #:______________ Group#:__________

Insurance Co:________________________

Ins. Co. Address ________________________

City______________ State______ Zip__________

Primary Medical Insurance

(please give copy of ins. card to receptionist)

Ins. Co. Name______________ Insured's Name______________

ID#______________ Group #______________

Patient's Health History

Child's Physician______________ Phone__________

May we request a release of your child's health history for our reference? YES NO

Date of last physical examination______________ Results__________

Question	YES	NO
Is child under care of physician now? Reason:______________	☐	☐
Is child receiving any medication or drugs? Type:______________	☐	☐
Is there excessive bleeding when cut?	☐	☐
Has child ever been hospitalized? If yes for what?______________	☐	☐
Are there any allergies to penicillin or other drugs? If yes to what______________	☐	☐
Are there other allergies: food-pollen-animals-dust-other?______________	☐	☐
Does child have good physical coordination?	☐	☐
Has child ever had surgery? If yes for what? ______________	☐	☐

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

____ ADHD/ADD	____ Cerebral Palsy	____ Fainting	____ Liver	____ Rheumatic Fever
____ AIDS	____ Chicken Pox	____ Hearing	____ Malignancies	____ Thyroid
____ Anemia	____ Chronic Sinus	____ Heart	____ Mastoid	____ Tuberculosis
____ Asthma	____ Convulsions	____ Hemophelia	____ Measles	____ Other
____ Autism	____ Diabetes	____ HIV Positive	____ Mononucleosis	____ Fragile X Syndrome
____ Bladder	____ Epilepsy	____ Kidney	____ Mumps	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

____

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered to myself or my dependent. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. If for some reason my account becomes delinquent, I agree to pay for all rebilling charges, interest charges, collection costs and legal fees. I authorize the dental group to send recall and concern postcards regarding my dental treatment through the mail. I consent to examination and treatment by Dr. Paul Rynders and Associates. I understand that a credit report may be pulled if necessary prior to extending financial arrangements. If for some reason the account should become delinquent, I agree to pay for all rebilling charges, interest charged, collection costs and legal fees. I acknowledge that I received a copy of this office's Notice of Privacy Practices. I understand that this signature will remain valid unless revoked by me in writing.

Printed Name______________ Signature______________ Date__________