SALLY C. POWELL | DDS

We are pleased to welcome you to our practice. Please fill out this form and email it back to sally@sallypowelldds.com If you have any questions, contact us at 573-474-8566 and we would be happy to help. We look forward to working with you in maintaining your child's dental health.

Name of Minor/Child: _____ Nickname: _____
First, Middle, Last

Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Sex: ❑ M ❑ F

Home Address: _____

_____
City *State* *Zip Code*

Name of School: _____ School Phone: _____

Person financially responsible: _____

Home Phone: _____ Work Phone: _____

Whom may we thank for referring you? _____

Insurance Information

Father's/Guardian's Name: _____

Address (if different from patient's): _____

_____

Home Phone: _____ Work Phone: _____

Email: _____

Employer: _____

Soc. Sec. #: _____ Birthdate: _____

Do you have dental insurance coverage for minor/child? ❑ YES ❑ NO

Plan Name: _____ Phone: _____

Address: _____

_____

Group # _____ Policy #: _____

Mother's/Guardian's Name: _____

Address (if different from patient's): _____

_____

Home Phone: _____ Work Phone: _____

Email: _____

Employer: _____

Soc. Sec. #: _____ Birthdate: _____

Do you have dental insurance coverage for minor/child? ❑ YES ❑ NO

Plan Name: _____ Phone: _____

Address: _____

_____

Group # _____ Policy #: _____

Dental History

Date of last visit to a dentist: _____ For what service? _____

Has child complained about dental problems? ❑ YES ❑ NO

Does child brush teeth daily? ❑ YES ❑ NO

Does child use floss daily? ❑ YES ❑ NO

Any mouth habits – *thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?* ❑ YES ❑ NO

Is fluoride taken in any form? ❑ YES ❑ NO

Any injuries to mouth, teeth, head? ❑ YES ❑ NO

Any unhappy dental experiences? ❑ YES ❑ NO

_____

Please complete both sides

Dental History

Minor/Child's Physician: _____

City/State: _____ Phone: _____ Date of last physical examination: _____

Is Minor/Child under physician care now? YES ❑ NO ❑
Receiving any medication or drugs? YES ❑ NO ❑
Ever been hospitalized? YES ❑ NO ❑
Ever had surgery? YES ❑ NO ❑
Is there excessive bleeding when cut? YES ❑ NO ❑

Medications: _____

Allergies: _____

Has the minor/child had any history of or difficulty with any of the following? Please check all that apply.

❑ AIDS/HIV positive	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney disease	❑ Rheumatic Fever
❑ Anemia	❑ Chicken Pox	❑ Fainting	❑ Liver disease	❑ Sinus problems
❑ Asthma	❑ Convulsions	❑ Hearing problems	❑ Measles	❑ Thyroid Disease
❑ Bladder problems	❑ Diabetes	❑ Heart problems	❑ Mononucleosis	❑ Tuberculosis
❑ Cancer	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.

Minor/Child Consent: I am the parent, guardian, or personal representative of _____
Please print name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent, I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release: I certify that my dependent(s) is covered by insurance and assign directly to **Dr. Sally Powell** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Signature _____ Date _____
Parent, Guardian or Personal Representative

Please Print Name _____ Relationship to patient _____
Parent, Guardian or Personal Representative