



SALLY C. POWELL | DDS
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WELCOME | We are please to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

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

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: _____ 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 Medications: _____

Receiving any medication or drugs? YES NO _____

Ever been hospitalized? YES NO Allergies: _____

Ever had surgery? YES NO _____

Is there excessive bleeding when cut? YES NO _____

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

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> 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