# Patient Medical History

Child's DOB _____________ Date______________________

CHILD'S FULL NAME_________________________________________________
LAST FIRST MIDDLE

FATHER'S NAME_______________________________________ CELL PHONE:_____________________________

ADDRESS________________________________________________ EMAIL:__________________________
STREET CITY STATE ZIP

MOTHER'S NAME______________________________________ CELL PHONE:_____________________________

ADDRESS________________________________________________ EMAIL:__________________________
STREET CITY STATE ZIP

Do parents live together?______Yes______No (if not, with whom does the child live?)_________________

Father's Occupation/Employer_________________________________________________________________

Address_____________________________________________________Phone:_________________________
Street City State Zip

Mother's Occupation/Employer________________________________________________________________

Address_____________________________________________________Phone:_________________________
Street City State Zip

**CHILD'S DENTAL AND MEDICAL HISTORY**

Is this your child's first visit to the dentist? ____No ____Yes

Does your child drink fluoridated water? ____No ____Yes

Is your child taking fluoride tablets/drops? ____No ____Yes

How often are your child's teeth brushed?_________________________By whom?_________________________

What type of toothpaste does your child use?________________________________________________________

Does your child suck his thumb, finger or lip? ____No ____Yes (Which_____________________________________)

Has your child had problems with previous dental treatment? ____No ____Yes (What was the problem?)

_____________________________________________________________________________________________

Does your child have a dental condition about which you are especially concerned? ____No ____Yes

(If yes, what is the condition?) _______________________________________________________________

Indicate whether your child presently has or has previously had any of the following conditions:

- ___ Adrenal disorders
- ___ Anemia
- ___ Bleeding tendency
- ___ Blood disease
- ___ Bone disorder
- ___ Brain disorder
- ___ Convulsions
- ___ Diabetes
- ___ Epilepsy
- ___ Ear disorders
- ___ Eye disorders
- ___ Fainting
- ___ Heart condition/surgery
- ___ Hemophilis
- ___ Hepatitis
- ___ High blood pressure
- ___ Jaundice
- ___ Liver disease
- ___ Lung disease
- ___ Mental issues
- ___ Muscle disorder
- ___ Nose/throat disorder
- ___ Prolonged illness
- ___ Rheumatic fever
- ___ Skin disease
- ___ Speech problem
- ___ Stomach problem
- ___ Tumors

Is your child taking any medicine? ____No ____Yes (What_______________________________________________)

Is your child allergic to any antibiotics/anesthetics ____No ____Yes (What________________________________)

Has your child ever been hospitalized? ____No ____Yes (Explain_______________________________________

_____________________________________________________________________________________________)

Child's Physician____________________________________________Phone:___________________________

How did you choose this office for your dental care?

____referral (Name:____________________) ____internet ____location ____other (please specify)__________________

In compliance with the TRUTH IN LENDING LAW, our credit policy is as follows:

It is customary to take care of the fee at the time service is rendered. We accept cash, check, VISA, Master Card, Discover, and Care Credit. On reconstruction cases (crown and bridge, implants, partials and dentures) 50% of the fee is due at the time treatment begins and the balance is due before insertion.

If you have dental insurance we will accept assignment from your company provided you pay your deductible and co-payment at the time of the visit with the understanding that you are responsible for any portion not paid by your company within 60 days. A 15% APR finance charge will be assessed on all account balances over 60 days.

If we are unable to verify your coverage/benefits prior to your visit, we will ask you to pay for the visit in full and have the insurance company reimburse you directly.

## DENTAL INSURANCE INFORMATION

INSURANCE NAME:____________________________ PHONE____________________

INSURANCE ADDRESS:_______________________________________________

SUBSCRIBER NAME:_________________________________________________

SUBSCRIBER POLICY OR ID#:______________________ GROUP #____________________

SUBSCRIBER EMPLOYER:______________________________________________

SUBSCRIBER SSN:____________________ SUBSCRIBER DATE OF BIRTH:____________________

______Accounts are considered delinquent after 60-days and will automatically be turned over to collections and 2 national credit companies unless patients have contacted our front office to make arrangements for payment in full.

I authorize release of any information to process insurance claims and collect payment for services.

Signed______________________________________________________________

I authorize payment of benefits directly to Davis and Ferguson Family Dentistry and understand that I am financially responsible for the charges not covered by this authorization.

Signed______________________________________________________________

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE AND HAVE READ AND AGREE TO THE POLICIES LISTED ABOVE.

Signed________________________________________ Date____________________

**OFFICE USE ONLY:**

| No Changes: Initial | Date | No Changes: Initial | Date |
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