~ WELCOME ~

PATIENT AND FAMILY INFORMATION

CHILD'S FULL NAME_____ PERFERRED NAME_____ ❑ MALE ❑ FEMALE
BIRTHDATE_____ SOCIAL SECURITY NUMBER_____

❑ CASH/CHECK ❑ CREDIT CARD ❑ INSURANCE ❑ OTHER_____

NAME OF MOTHER/GUARDIAN_____ BIRTHDATE_____
SOCIAL SECURITY NUMBER_____ HOME PHONE_____ CELL PHONE_____
MAILING ADDRESS_____
CITY_____ STATE_____ ZIP_____
EMPLOYER_____ BUSINESS PHONE_____
INSURANCE INFORMATION_____
NAME OF FATHER/GUARDIAN_____ BIRTHDATE_____
SOCIAL SECURITY NUMBER_____ HOME PHONE_____ CELL PHONE_____
MAILING ADDRESS_____
CITY_____ STATE_____ ZIP_____
EMPLOYER_____ BUSINESS PHONE_____
INSURANCE INFORMATION_____

CHILD'S DENTAL HISTORY

DATE OF LAST DENTAL VISIT_____ DENTIST'S NAME_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

❑ THUMB/FINGER SUCKING ❑ FINGERNAIL BITING ❑ GRINDING TEETH
❑ LIP OR CHEEK BITING ❑ JAW DIFFICULTY: CLICKING AND/OR WITH PAIN

CHILD'S HEALTH HISTORY PLEASE CHECK ALL THAT APPLY:

❑ ALLERGIC TO ANY MEDICATION_____
❑ ANY OTHER ALLERGIES_____

❑ ANEMIA	❑ DIABETES	❑ HEART MURMUR	❑ SCARLETT FEVER
❑ ASTHMA	❑ EPILEPSY	❑ HEPITTAS-TYPE ____	❑ TONSILLITIS
❑ CANCER	❑ HIV/AIDS	❑ RHEUMATIC FEVER	

❑ OTHER_____

ASSIGNMENT AND RELEASE

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCCURRED BY MY CHILD REGUARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS AND TO ASSIGN PAYMENTS TO BE MADE DIRECTLY TO CHILDREN'S DENTISTRY OF ROME. THIS SIGNATURE ALSO ACKNOWLEDGES THAT I HAVE BEEN GIVEN ACCESS TO AND UNDERSTAND THE PRIVACY PRACTICES OF CHILDREN'S DENTISTRY OF ROME AND I FULLY AUTHORIZE THE USE OF THIS SIGNATURE IN GATHERING AND/OR RELEASING INFORMATION FROM OTHER DENTAL AND/OR MEDICAL FACILITIES THAT MAY BE VITAL IN THE TREATMENT OF MY CHILD.

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SIGNATURE OF RESPONSIBLE PARTY