Bruce A. Weitz, D.D.S. Inc.

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WELCOME

We are pleased 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.

PATIENT INFORMATION

Date _____ Birthdate _____

Name of Minor/Child _____ _____ _____ Sex ○ Male ○ Female Age _____
Last Name First Name Middle Name

Nickname _____ Hobbies _____ Cell Phone _____

Home Address _____ City, State, Zip _____

Mailing Address _____ City, State, Zip _____

School Name _____ School Phone _____

Person finalcially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you _____

INSURANCE

Father's/Guardian Name _____

Address (if different from patient's) _____

Home Phone _____ Work Phone _____

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child ○ Yes ○ No

Plan Name _____ Phone _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ○ Yes ○ No

Mother's/Guardian Name _____

Address (if different from patient's) _____

Home Phone _____ Work Phone _____

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child ○ Yes ○ No

Plan Name _____ Phone _____

Address _____

Group # _____ Policy # _____

Child's Medical Assistance I.D. # _____

DENTAL HISTORY

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

	Yes	No		Yes	No
Has child complained about dental problems? _____	○	○	Is fluoride taken in any form? _____	○	○
Does child brush teeth daily? _____	○	○	Any injuries to mouth, teeth, head? _____	○	○
Does child use floss everyday? _____	○	○	Any unhappy dental experiences? _____	○	○
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc. _____				○	○

MEDICAL HISTORY

Minor Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No	
Is Minor/Child under care of physician now?	○	○	Medications _____
Receiving any medication or drugs?	○	○	_____
Ever been hospitalized	○	○	_____
Ever had surgery?	○	○	Allergies _____
Is there excessive bleeding when cut?	○	○	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check below.

☐ AIDS	☐ 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

In the event of an emergency, whom should we 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 _____

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 name 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 with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes 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 above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE - TO BE COMPLETED AT LATER DATE

Has there been any change in patient's health since last dental appointment? ○ Yes ○ No

If yes, please describe _____

Is patient taking any medications? ○ Yes ○ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____