CHILD FORM

Child's First Name:	Last Name:	Sex: M / F
Date of Birth: / /	Email: ONLY Provide to receive updates & reminders	Social Security#: - -

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:
How did you hear about our office?	

PARENT'S INFORMATION

Mother's Information	Father's Information
Full Name:	Full Name:
Home#:	Home#:
Work#:	Work#:
Employer's Name:	Employer's Name:
Social Security#: - -	Social Security #: - -
Date of Birth: / /	Date of Birth: / /

Child's Health History

How often does your child brush per day?	Any Dental concerns?	
Previous Dentist:	Date of last visit:	Is your Child's water fluoridated?
Physician's Name:	*Does your child need to pre-medicate?	
Is your child under physicians care now?	*If yes explain	

Has your child ever had a serious head or neck injury?	If yes, please explain:
Is your child taking any medications, pills, or drugs?	If yes, please list:

WOMEN ONLY	Are you Pregnant/Trying to get pregnant? Y / N If **Yes** Due Date: / /	Taking oral contraceptives? Y / N	Nursing? Y / N

Is your Child Allergic to the following: Please Circle all that apply

Aspirin	Penicillin	Codeine	Local Anesthetics	Acrylic	LATEX	Sulfa Drugs	Metal	Other: Explain:	Denies All

Insurance Information

Insured's Full Name:	Insured Birth date: / /	Group#:
Insured's Social Sec #: - -	Employer:	Member/Subscriber ID:

Insurance Company:	Phone:
Address:	City, State, & Zip:

MEDICAL HISTORY

Does your Child have or had any of the following: Please Circle Yes or No

AIDS/HIV Positive	Yes	No	**Cortisone Medicine**	Yes	No	**Hemophilia**	Yes	No	**Renal Dialysis**	Yes	No
Alzheimer's Disease	Yes	No	**Diabetes**	Yes	No	**Hepatitis A**	Yes	No	**Rheumatic Fever**	Yes	No
Anaphylaxis	Yes	No	**Drug Addiction**	Yes	No	**Hepatitis B or C**	Yes	No	**Rheumatism**	Yes	No
Anemia	Yes	No	**Easily Winded**	Yes	No	**Herpes**	Yes	No	**Scarlet Fever**	Yes	No
Angina	Yes	No	**Emphysema**	Yes	No	**High Blood Pressure**	Yes	No	**Shingles**	Yes	No
Arthritis/Gout	Yes	No	**Epilepsy or Seizures**	Yes	No	**Hives or Rash**	Yes	No	**Sickle Cell Disease**	Yes	No
Artificial Heart Valve	Yes	No	**Excessive Bleeding**	Yes	No	**Hypoglycemia**	Yes	No	**Sinus Trouble**	Yes	No
Artificial Joint	Yes	No	**Excessive Thirst**	Yes	No	**Irregular Heartbeat**	Yes	No	**Spina Bifida**	Yes	No
Asthma	Yes	No	**Fainting Spells/Dizziness**	Yes	No	**Kidney Problems**	Yes	No	**Stomach/Intestinal Disease**	Yes	No
Blood Disease	Yes	No	**Frequent Cough**	Yes	No	**Leukemia**	Yes	No	**Stroke**	Yes	No
Blood Transfusion	Yes	No	**Frequent Diarrhea**	Yes	No	**Liver Disease**	Yes	No	**Swelling of Limbs**	Yes	No
Breathing Problem	Yes	No	**Frequent Headaches**	Yes	No	**Low Blood Pressure**	Yes	No	**Thyroid Disease**	Yes	No
Bruise Easily	Yes	No	**Genital Herpes**	Yes	No	**Lung Disease**	Yes	No	**Tonsillitis**	Yes	No
Cancer	Yes	No	**Glaucoma**	Yes	No	**Mitral Valve Prolapse**	Yes	No	**Tuberculosis**	Yes	No
Chemotherapy	Yes	No	**Hay Fever**	Yes	No	**Pain in Jaw Joints**	Yes	No	**Tumors or Growths**	Yes	No
Chest Pains	Yes	No	**Heart Attack/Failure**	Yes	No	**Parathyroid Disease**	Yes	No	**Ulcers**	Yes	No
Cold Sores/Fever Blisters	Yes	No	**Heart Murmur**	Yes	No	**Psychiatric Care**	Yes	No	**Venereal Disease**	Yes	No
Congenital Heart Disorder	Yes	No	**Heart Pace Maker**	Yes	No	**Radiation Treatments**	Yes	No	**Yellow Jaundice**	Yes	No
Convulsions	Yes	No	**Heart Trouble/Disease**	Yes	No	**Recent Weight Loss**	Yes	No			

Has your child ever had any serious illness not listed above:	If yes, please explain:

Agreement & Authorization

I give Dunwoody Park Family Dentistry permission to treat my child with cleaning, x-rays, sealants, fluoride treatments, and if cavities are diagnosed, to have treatment rendered (including permission to use local anesthesia and/or Nitrous for patients comfort, if necessary).__________***initial***

I understand that keeping appointments is very important. If I cannot keep an appointment for any reason, I must give at least 24 hour notice. Failure to provide 24 hour notice for a missed appointment may prevent me from being able to reserve or make future appointments in advance. I understand that my health insurance carrier may pay less than the actual cost of services rendered on my behalf and my dependents, and that I am responsible for the difference. I realize that failure to keep my account current may result in Dunwoody Park Family Dentistry being unable to provide additional services. I certify that I have read & understand the above information. I understand that providing incorrect information can be dangerous to my health. I give Dunwoody Park Family Dentistry permission to perform dental treatments on myself and my dependents, which may include anesthesia for the patient's comfort. I authorize Dunwoody Park Family Dentistry to leave messages on my home answering machine or cell phone voicemail concerning appointments, scheduled treatment including pre-med reminders, as well as payment information. I authorize Dunwoody Park Family Dentistry to use or disclose any necessary health information (PHI) in order to carry out treatment, payment activities, and healthcare operations, as fully described in our Notice of Privacy Practices. I understand that upon request I will receive a copy of the Notice of privacy policies as prescribed by the Health Insurance Portability and Accountability Act of 1996(HIPPA).

***Signature of Parent or Guardian*:____ Date:____________________**