



**PATIENT INFORMATION**

Email: \_\_\_\_\_

**Child's Name** \_\_\_\_\_  
Last Name First Name Middle Initial

Male      **Age** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Nickname** \_\_\_\_\_ **Hobbies** \_\_\_\_\_  
 Female

**Home Address** \_\_\_\_\_  
Street Apt # City State Zip Code

**Mailing Address** \_\_\_\_\_  
Street Apt # City State Zip Code

**Home Phone #** \_\_\_\_\_ **Mom Cell #** \_\_\_\_\_ **Dad Cell #** \_\_\_\_\_

Does your child have Georgia Medicaid/Peachcare? Yes No ID# \_\_\_\_\_  
Circle One

Whom may we thank for referring you? \_\_\_\_\_

**INSURANCE/PARENT'S INFORMATION**

**Circle One:** Father      Stepfather      Guardian

**Name** \_\_\_\_\_

**Address (if different from patient)** \_\_\_\_\_

---

**Home Phone** \_\_\_\_\_  
(if different from above)

**Work Phone** \_\_\_\_\_  
(if different from above)

**Employer** \_\_\_\_\_

**Social Security #** \_\_\_\_\_

**Birthdate** \_\_\_\_\_

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

**Insurance Co.** \_\_\_\_\_

**Phone #** \_\_\_\_\_

**Claims Address** \_\_\_\_\_

---

**Group #** \_\_\_\_\_

**Policy/I.D. #** \_\_\_\_\_

**Circle One:** Mother      Stepmother      Guardian

**Name** \_\_\_\_\_

**Address (if different from patient)** \_\_\_\_\_

---

**Home Phone** \_\_\_\_\_  
(if different from above)

**Work Phone** \_\_\_\_\_  
(if different from above)

**Employer** \_\_\_\_\_

**Social Security #** \_\_\_\_\_

**Birthdate** \_\_\_\_\_

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

**Insurance Co.** \_\_\_\_\_

**Phone #** \_\_\_\_\_

**Claims Address** \_\_\_\_\_

---

**Group #** \_\_\_\_\_

**Policy/I.D. #** \_\_\_\_\_

**DENTAL HISTORY**

**Date of last visit to a dentist** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Last Cleaning/Fluoride** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Last X-Rays** \_\_\_\_/\_\_\_\_/\_\_\_\_

Has child complained about dental problems?    Yes    No      Is fluoride taken in any form?      Yes    No

Does child brush teeth daily?      Yes    No      Any injuries to mouth, teeth, head?    Yes    No

Does child floss every day?      Yes    No      Any unhappy dental experiences?    Yes    No

Any mouth habits?    \_\_\_ thumb sucking    \_\_\_ nail biting    \_\_\_ mouth breathing    \_\_\_ pacifier    \_\_\_ sleeping with bottle

Other (please explain) \_\_\_\_\_

**NAME AND PHONE NUMBER OF PREVIOUS DENTIST:** \_\_\_\_\_

Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Current Medical Conditions \_\_\_\_\_

List of ALLERGIES (LATEX etc) \_\_\_\_\_

	Yes	No	
Has child ever been diagnosed with heart murmur?	_____	_____	Is SBE prophylaxis required? _____
Is child receiving any medication or drugs?	_____	_____	List Medications _____
Has child ever been hospitalized?	_____	_____	If so, why? _____
Has child ever had surgery?	_____	_____	List surgeries _____
Is there excessive bleeding when cut?	_____	_____	Handicaps/Disabilities? _____

**HAS CHILD EVER HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE**

- |                                  |   |                      |                 |
|----------------------------------|---|----------------------|-----------------|
| ADD/ADHD                         | Cerebral Palsy  | Hearing Impairment   | Mononucleosis   |
| AIDS/HIV                         | Chicken Pox   | Heart Murmur         | Mumps           |
| Anemia (Sickle cell or Low Iron) | Congenital Heart Defect   | Hepatitis            | Rheumatic Fever |
| Asthma                           | Convulsions/Seizures  | Hemophilia           | Sinus Problems  |
| Artificial Heart Valves          | Diabetes  | Kidney/Liver Disease | Thyroid Disease |
| Autism                           | Drug/Alcohol Abuse  | Learning Disability  | Tuberculosis    |
| Bladder Problems                 | Epilepsy  | Measles              | Cancer/Tumors   |
| Fainting                         | Psychological Problems (example:DD/communication skillsdisorders) |                      |                 |

Other (please explain) \_\_\_\_\_

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EMERGENCY CONTACT**

In the event of an emergency, whom should we contact? \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**CONSENT FOR TREATMENT**

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Nath/authorized staff to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine (Novacaine-like), and any necessary x-rays on my child. ALL PROCEDURES WILL ALWAYS BE DISCLOSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**FINANCIAL AGREEMENT**

- We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.
- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.
- If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due.
- Your insurance card must be presented at every visit. If there is no insurance card then payment (cash, check, or credit card) is expected at the time of service.
- I hereby authorize payment directly to ROSWELL/CANTON PEDIATRIC DENTISTRY PC, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.
- A fee will be charged to your account if there is a history of broken appointments with less than 24 hours notice.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_