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_____________________ SS/HIC/Patient ID#_____________________ Birthdate____/____/______

Name of Minor/Child____ Sex: ☐ Male ☐ Female Age:______
Last Name First Name Middle Initial

Nickname: _______________________ Hobbies: _____________________________ Cell Phone: (____)________________

Home Address: ____
Street City State Zip Code

Mailing Address: ____
Street City State Zip Code

School Name: ____ School Phone: (____)____________________

Person Financially Responsible: ___________________________________ Home Phone: (____)____________________

Whom may we thank for referring you? ____

Insurance Information

Father's/Guardian's Name: _______________________________

Address (If different from patient's): ________________________

____

Home Phone: (____)_____________ Cell: (____)_____________

Email: __________________________________

Employer: _______________________________

SS#: ______-_____-_________ Birthdate: ____/____/______

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

Plan Name: ______________________ Phone:(____)_____________

Address: ____

Group#: __________________ Policy: ____________________

Mother's/Guardian's Name: _____________________________

Address (If different from patient's): ______________________

____

Home Phone: (____)_____________ Cell: (____)_____________

Email: __________________________________

Employer: _______________________________

SS#: ______-_____-_________ Birthdate: ____/____/______

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

Plan Name: __________________ Phone:(____)___________

Address: ____

Group#: __________________ Policy: ____________________

Date of last visit to a dentist: ________________________________ For what service ? _____________________________

Has child complained about dental problems? ☐Yes ☐No

Does child brush teeth daily? ☐ Yes ☐ No

Does child use floss every day? ☐ Yes ☐ No

Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any unhappy dental experience? ☐ Yes ☐ No

Any mouth habits-thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, ect.? ☐ Yes ☐ No

Medical History

Minor/Child's Physician: ____________________ City/State: ____________________ Phone:(____)__________________

Date of last physical examination: ______________________________ Results: ______________________________________

Is Minor/Child under care of physician now?... ☐ Yes ☐ No Medications: ____

Receiving any medication or drugs?................ ☐ Yes ☐ No ____

Ever been hospitalized?..................................☐ Yes ☐ No ____

Ever had surgery? …………………………………………☐ Yes ☐ No Allergies: ____

Is there excessive bleeding when cut? ………….☐ Yes ☐ No ____

Has minor/child had any history of or difficulty with any of the following? If yes, please (√)

□ AIDS/HIV	□ Cerebral Palsy	□ Epilepsy	□ Kidney Disease	□ Rheumatic Fever
□ Anemia	□ Chicken Pox	□ Fainting	□ Liver Disease	□ Sinus Problems
□ Asthma	□ Convulsions	□ Hearing Problems	□ Measles	□ Thyroid Problems
□ 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: (____)_______________

Authorizations

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 named 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 ___________________________ and assign directly to Dr. Ciaglia all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges 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 any 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 Parent, Guardian, or Personal Representative Date

____ ____________________

Please print name of Parent, Guardian or Personal Representative Date

Consent to Dental Photography: I authorize New Lenox Dental Group to take photographs, and/or videos of my face, jaws, and teeth, before, during and after treatment. I consent to allow the photographs to be used for:

- Dental Records and Dental Research,
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient or Guardian) ____ Date: _____________