toothtales™

GENERAL INFORMATION

Circle your relationship to the patient? mother / father / guardian / other

Your general dentist ..... Marital status: single / married / divorced / widowed

Father: ..... SSN: ..... Birthdate: ..... DL#: .....

Mother: ..... SSN: ..... Birthdate: ..... DL#: .....

Home phone: ..... cell phone: ..... email: .....

Home address: .....

street city, state zip code

Do you have legal custody of the child? Y / N

Person financially responsible for child's dental care: .....

DENTAL HISTORY

Is this your child's first dental visit? Y / N if no, previous dentist? .....

Date of last visit ..... How was his / her experience? .....

Child's attitude towards the dentist or dental treatment: .....

Has your child had any injuries to teeth, mouth or head? Y / N if yes, please describe: .....

Has your child done any of the following (past or present)? please circle

thumb/finger sucking pacifier nail biting tongue sucking mouth breathing

teeth grinding snoring nursing bottle-feeding

Is your water fluoridated? Y / N Does your child take fluoride supplements? Y / N

Does your child use fluoridated toothpaste? Y / N

How often does your child brush his/her teeth? ....with adult supervision? Y / N

How often does he/she floss? .....

How can we help to make the visit a positive experience for your child? .....

.....

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FINANCIAL AGREEMENT

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for true dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion at the time of dental treatment.

For patients without insurance: Payment in full is expected at the time of dental treatment. When this is not possible, financial arrangements must be made in advance. I realize that failure to keep this account current may result in the dentist unable to provide additional true dental services except for dental emergencies or where there is prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

A special time is reserved for your child to allow quality time for your child, for missed dental treatment appointments (without at least a 24 hour notice) there will be a $35 charge.

SIGNATURE: ..... Relationship: ..... date: .....