DUNBAR Smiles

DR. SABEEN TIWANA

Today's Date_____

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name_____

Nickname _____ Sex _____

Birthdate _____ Age_____

School _____ Grade _____

Child's Home Address_____

City _____ State _____ Zip_____

Phone _____

Responsible Party

Name_____

Relationship _____

Address_____

City _____ State _____ Zip _____

E-Mail_____

SS #_____

Who can we thank for referring you? _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone_____

Work Phone _____ Ext._____

Best time to call _____

Time _____ Days _____

_____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext._____

E-Mail _____

Employer _____

Occupation_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

E-Mail_____

Employer _____

Occupation _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name_____

Relationship _____

Birthdate _____ SS #_____

Insurance Company _____

Group # _____ Employee #_____

Additional Insurance

Insured's Name_____

Relationship _____

Birthdate _____ SS #_____

Insurance Company _____

Group # _____ Employee #_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check ☐ Credit Card ☐ Financial Options

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Dental & Health History *CONFIDENTIAL*

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck thumb/finger ☐ Yes ☐ No Chew hard objects (pencils, etc.) ☐ Yes ☐ No

Suck/Bite lip ☐ Yes ☐ No Grind teeth ☐ Yes ☐ No

Bite/Chew nails ☐ Yes ☐ No Clench jaws ☐ Yes ☐ No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illness? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes, please describe) _____

Does your child have a history of allergies to any other substance (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No Stomach, liver or kidney problems ☐ Yes ☐ No

Cancer ☐ Yes ☐ No Handicaps/Disabilities ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No Congenital Heart Defect ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Abnormal Bleeding ☐ Yes ☐ No Convulsions/Epilepsy ☐ Yes ☐ No

Please explain any medical problems that your child has: _____

_____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of patient or parent if minor Date

Dentist Review:

_____ _____

Signature of Dentist Date