Quality Dental Care

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOUR CHILD

Today's Date: _____

Name: _____ (LAST FIRST)

I prefer to be called: _____ ☐Male ☐Female

Birthdate: _____ Age: ____ SSN: _____

Home Address: _____

_____ (CITY STATE ZIP)

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____

Do you have legal custody of this child? _____

Who may we thank for referring you? Please Circle

Mailer Google Live in Bennington Driveby
Billboard YMCA Directory/Magazine
Family/Friend (Name) _____
Other: _____

Other family members seen by us: _____

MOTHER'S INFORMATION

Name: _____ (LAST FIRST)

Employer: _____

Work #: _____ Ext: _____

Birthdate: _____ Age: ____ SSN: _____

Cell #: _____ Email: _____

FATHER'S INFORMATION

Name: _____ (LAST FIRST)

Employer: _____

Work #: _____ Ext: _____

Birthdate: _____ Age: ____ SSN: _____

Cell #: _____ Email: _____

WHO HAS ACCESS TO THIS CHILD'S ACCOUNT: _____

Our goal is to make your visit to our office enjoyable. In order to give you the services you expect and deserve, please let us know what is important to you to help us improve your dental visit.

_____

_____

_____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Holder: _____ Relation: _____

Policy Holder's Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy Holder: _____ Relation: _____

Policy Holder's Birthdate: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Cell #: _____ Other #: _____

MEDICAL HISTORY

Do you have a personal physician? _____

Physician's Name: _____

Phone #: _____

Date of last visit: _____

DENTAL HISTORY

Why is the child at the dentist today?

_____

_____

Is the child currently in pain? If so, please explain.

_____

_____

_____

Has the child ever had a serious/difficult problem associated with any previous dental work? If so, please explain.

_____

_____

Has the child had or ever experienced pain/discomfort in their jaw joint? (TMJ/TMD)

_____

_____

Child's current dental health is... Please circle.

Good Fair Poor

Does the child take fluoridated supplements?

☐Yes ☐No

Do your gums bleed?

☐Yes ☐No

How many times a week do they floss? _____

How many times a day do they brush? _____

Type of bristles? Please circle.

Hard Medium Soft

Have they had orthodontic treatment?_____

Do they clench or grind their teeth? _____

Is their mouth sensitive to cold, hot, or pressure?_____

Does the child have any of these habits?

_____ Thumb/Finger Sucking
_____ Lip Sucking/Biting
_____ Nail Biting
_____ Nursing Bottle Habits

_____ **I authorize** the dental staff to perform any necessary dental service that I may need during diagnosis and treatment.

_____ **I understand** 6 month appointments routinely consists of an exam, prophylaxis (cleaning), and a fluoride treatment (for all children under 16 and as recommended by Doctor otherwise). Bitewing x-rays will be taken at least once per year as recommended by Doctor, and a full mouth x-ray will be updated every three years. These are our standards of care to give each patient the best service we can provide. Each employer's policy has different allowances and limitations. Since it is the patient who has the contract with the insurance, it is your responsibility to know your insurance coverage. If you have any questions regarding your treatment, you must ask before treatment's rendered.

_____ **I agree** to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contracted agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I consent to your use a disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims.

_____ **I understand** that all payments at the time of the appointment are estimates only and I am responsible for all charges incurred on my account that are not covered by insurance. I understand that all balances on my account are due in full within 60 days are subject to a 16% APR finance charge and $75.00 collection fee if assigned to our collection agency .

_____ **I acknowledge** that I have received access to the office's Notice of Privacy Practices.

_____ **I authorize** the release of any of my dental information including proposed treatment plans, procedure fees, and dental history to the following individuals: _____

_____

Signature Date Relationship

_____

Signature Date Relationship

Since appointments time are reserved just for the patient scheduled, we require 24 hours notice to change appointments without a charge.