



D O W N T O W N  
**Family Dental**  
*of baraboo*

Downtown Family Dental would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. Thank you for selecting Downtown Family Dental for your dental healthcare team.

Today's Date \_\_\_\_\_

**Patient Information (Confidential)**

Name of Child \_\_\_\_\_

Last

First

Middle

Male \_\_\_ Female \_\_\_ Birthdate \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Address \_\_\_\_\_

Street

P.O. Box

City

State

Zip Code

Hobbies \_\_\_\_\_

Contact Person in Case of Emergency \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

**Responsible Party/Insurance Information**

Father/Guardian's Name \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Driver's License No. \_\_\_\_\_

Driver's License No. \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

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

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

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

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

Medical History

Child's Physician \_\_\_\_\_

Telephone # \_\_\_\_\_

Date of last exam \_\_\_\_\_

Is child under care of physician now? YES NO  
\_\_\_\_\_

Is child receiving any medications? \_\_\_\_\_

Has child ever been hospitalized? \_\_\_\_\_

Has child ever had surgery? \_\_\_\_\_

Are there any emotional problems? \_\_\_\_\_

Is child in good physical condition? \_\_\_\_\_

Is pre-medication recommended before dental treatment? \_\_\_\_\_

Is child allergic latex? \_\_\_\_\_

Medications Taken \_\_\_\_\_

Medicine Allergies \_\_\_\_\_

Has child had a history of or difficulty with any of the following?

- |              |                    |                        |
|--------------|--------------------|------------------------|
| ___ AIDS/HIV | ___ Cerebral Palsy | ___ Epilepsy           |
| ___ Anemia   | ___ Chicken Pox    | ___ Fainting           |
| ___ Asthma   | ___ Convulsions    | ___ Hearing            |
| ___ Bladder  | ___ Diabetes       | ___ Heart              |
| ___ Cancer   | ___ Hepatitis      | ___ Mumps              |
| ___ Sinuses  | ___ Measles        | ___ Mono               |
| ___ Kidneys  | ___ Drugs/Alcohol  | ___ Bleeding           |
| ___ Liver    | ___ Malignancies   | ___ Rheumatic<br>Fever |

Other (Please Explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dental History

Date of last dental visit \_\_\_\_\_

What was appt. for? \_\_\_\_\_

Any unhappy dental experiences? (Please explain)

\_\_\_\_\_  
\_\_\_\_\_

Child's Attitude towards dentistry? \_\_\_\_\_

Chief Dental Complaint \_\_\_\_\_

Has child complained about dental problems? YES NO  
\_\_\_\_\_

Does child brush/floss teeth daily? \_\_\_\_\_

Is fluoride taken in any form? \_\_\_\_\_

Has child had any injuries to mouth, teeth, or head? \_\_\_\_\_

Any mouth habits: thumbsucking, nail biting, mouth breathing, bottle/pacifier? \_\_\_\_\_

**LATE CHARGES.** If I do not pay the entire balance within 60 days of the date of service, a late charge of 1.5% monthly, 18% annually on the balance unpaid and owed will be accessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services.

**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 harmful to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I understand that my dental 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 family.

Signed \_\_\_\_\_ Date \_\_\_\_\_