

Patient Name _____

DENTAL HISTORY

Does your child regularly brush his/her teeth?	yes	no	Does your child have any sensitive teeth?	yes	no
Does your child have his/her teeth flossed?	yes	no	Does your child have any gum swelling?	yes	no
Does your child have sores in his/her mouth?	yes	no	Does your child grind/clench their teeth?	yes	no
Does your child have mouth dental odor?	yes	no	Has your child had orthodontic treatment?	yes	no
Does your child fear dental treatment?	yes	no	Has your child been to the dentist before?	yes	no
Why? _____			How would you rate the visit? _____		

MEDICAL HISTORY

Does your child have now, or has ever had (PLEASE ANSWER EACH QUESTION)

Heart disease	yes	no	Bleeding problems	yes	no
Rheumatic fever	yes	no	Cancer	yes	no
heart murmur	yes	no	Hemophilia	yes	no
Blood disease	yes	no	Hearing impairments	yes	no
Anemia	yes	no	HIV positive	yes	no
Asthma	yes	no	Heart problems	yes	no
Epilepsy	yes	no	Hyperactivity	yes	no
Diabetes	yes	no	Hospital stays? Explain _____		

If you answered yes to any of these, please explain: _____

General health? Excellent Good Fair Poor Name of Physician? _____

List any medications your child takes: Phone # _____

_____ Purpose for medication? _____

Please list any and all medical conditions or diagnosis that your child has: _____

Is your child allergic to; Penicillin? Codeine? Local anesthetics? Any other allergies? _____

I understand that the information I have given is correct and accurate to the best of my knowledge. I understand that this information will not be shared except with my physician if needed. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental treatment on my child.

Signature of parent/legal guardian _____ Date _____

TIMOTHY W. ADAMS, D.D.S.

PATIENT INFORMATION

Patient's Name _____ Date of birth: _____

Address _____ City _____ Zip _____

Home Phone # _____ Nickname _____

Child resides with: Both Parents Mother Father Shared Custody Legal Guardian

How did you find out about our practice? _____

Mother's Name _____ Birth Date _____

Address _____ City _____ Zip _____

Home Phone # _____ SS# _____ - _____ - _____

Employer _____ Work Phone _____

Father's Name _____ Birth Date _____

Address _____ City _____ Zip _____

Home Phone # _____ SS# _____ - _____ - _____

Employer _____ Work Phone _____

Dental Insurance Information

Name of Insured _____ Birth Date _____

Insured's SS# _____ - _____ - _____ Relationship to patient _____

Insurance Co. _____ Phone # _____ Group # _____

Address _____ City _____ State _____ Zip _____

Dual Insurance Information

Name of Insured _____ Birth Date _____

Insured's SS# _____ - _____ - _____ Relationship to patient _____

Insurance Co. _____ Phone # _____ Group # _____

Address _____ City _____ State _____ Zip _____

I verify that all information above is accurate and will inform the office of any changes.

Signature _____ Date _____

Office Policies

When you schedule an appointment, we have a full staff scheduled for your child. If a patient does not show up, or cancels with less than 24 hours' notice, it is difficult for us to fill that time slot. All our patients are expected to keep their scheduled appointments. As a courtesy, our office will make an effort to remind you of your appointment; ultimately, however, it is your responsibility to remember your scheduled appointments. The fee for missed appointments and appointments canceled with less than 24 hours' notice is \$30 per half-hour scheduled, per child.

We will apply a \$20 charge for all returned checks. If your account is assigned to collections for nonpayment, all collections and attorney's fees will be applied to your account.

The fees for professional services rendered by Dr. Adams are the patient's responsibility. Dr. Adams' office will accept payment from an insurance company; however, all non-covered expenses will be the sole responsibility of the patient. Our office will diligently strive to provide the most accurate estimate of the co-payments due from the patient. However, insurance companies pay varying amounts for the same procedures; thus it is impossible for us to predict co-payments with 100% accuracy. There is a monthly \$5.00 re-billing fee for overdue balances.

Thank you for your understanding and cooperation!

Dr. Timothy Adams and Staff

I have read the office policies and accept the responsibility for any, and all, balances due on my account.

Print Parent's Name _____

Parent's Signature _____

Date _____