Mahomet Family Dentistry

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

We will strive to make your child's visits pleasant and comfortable.

Please Print.

Child's Name _____ Nickname: _____
First Middle Last

Sex: ☐ Male ☐ Female Age _____ Birthdate: _____

School _____ Grade _____ ☐ Full time ☐ Part time

Child's home address _____
Street or PO Box City State Zip

Who is responsible for Account? _____ Who is responsible for making appointments? _____

Brother and Sisters names and ages? _____

Parent or Guardian Information
☐ Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone # _____ Work Phone # _____

Employer _____

Occupation _____ Cell Phone # _____

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

Parent or Guardian Information
☐ Father ☐ Step father ☐ Guardian

Name _____

Home Phone # _____ Work Phone # _____

Employer _____

Occupation _____ Cell Phone # _____

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

Dental Insurance Information (If you have additional dental insurance please show us your card)

Name of person insurance is under: _____
First Middle Last

Birthdate: _____ Relationship to patient: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____

Name of Insurance _____ Address: _____ City: _____ State: _____ Zip: _____

ID # _____ Social Security # (Last 4 digits) _____ Union or Group # _____

Financial Policy

Payment in full is due on the day of service unless:

You have an accepted group dental insurance policy in effect that will pay us directly. You are expected to pay any remaining portion within 30 days of the insurance payment or processing. For the convenience of our patients, we will file all claims from our office on the date of service.

OR

Comprehensive treatment is incurred requiring additional visits and /or laboratory expenses. 50% of the total cost must be paid on the day of service with the remaining balance due on the next dental visit.

We do not offer monthly payment plans, however we do offer Care Credit. If you are interested in this we would be happy to explain this option to you. However we do accept Master Card and Visa, (credit or debit), checks, and/or cash.

Your cooperation with this policy will assure equitable treatment of all patients.

X _____
Signature of Parent or responsible party **Date**

Dental/Medical Health History (Confidential)

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

Child's name _____
First Middle Last

	Yes	No
Has your child worn braces	☐	☐
If yes, who is the orthodontist _____		
Is your child's water fluoridated?	☐	☐
Does your child take fluoride supplements?	☐	☐
How many times a day does your child brush? _____		
How many times a week does your child floss? _____		
Does your child:		
Suck Thumb/fingers	☐	☐
Suck/Bite lip	☐	☐
Bite/Chew nails	☐	☐
Chew hard objects (pencils, etc)	☐	☐
Grind teeth	☐	☐
Clench jaws	☐	☐
Use a pacifier	☐	☐
Date of last Dental Visit _____		
Previous Dentist _____		
Address _____		
Phone # _____		

Has your child ever had any of the following:	Yes	No
Asthma	☐	☐
Handicaps/Disabilities	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Tuberculosis (TB)	☐	☐
HIV/AIDS	☐	☐
Rheumatic Fever	☐	☐
Hemophilia	☐	☐
Congenital Heart Defect	☐	☐
Abnormal Bleeding	☐	☐
Heart Murmur	☐	☐
Stomach, Liver or Kidney Problems	☐	☐
Convulsions/Epilepsy	☐	☐
Has your child had difficulty with previous dental visits?	☐	☐
If yes, please explain _____		

Child's Medical Doctor _____ Phone # _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

_____ _____
_____ _____
_____ _____

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

_____

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

_____

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

Please explain any medical problems that your child has: _____

_____

Authorization and 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 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 the third party payers and /or 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 dependents.

X _____
Signature of patient or responsible party **Date**