



Date: _____

Child's Name: _____ Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F Age: _____ Birth date: ___ / ___ / ___ SS#: _____
(Circle One)

Name of Responsible Party: _____ Relationship to Child: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M / F Age: _____ Birth date: ___ / ___ / ___ Single Married Widow Separated Divorced SS#: _____
(Circle One) (Circle One)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Employer: _____

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

Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth	Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F				Yes	No	M	F		
_____							_____						
_____							_____						
_____							_____						
_____							_____						

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ___ / ___ / ___

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

Secondary Insurance Information

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ___ / ___ / ___

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Rainbow Kids Dental to check and verify my credit and/or employment history. I further understand that Rainbow Kids Dental will assist me in filing my child's claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my child's photos for educational purposes.

I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 5% per month. Thank you for your cooperation.

Parent or Guardian: _____

(please complete both side)

Medical History

Physician's name _____ Address _____ Phone _____

Date of Last visit _____ Results _____

Please indicate with a YES or NO. Does your child currently have/previously had any of the following health problems?

_____ Allergies (Food, Dust, Drug, Unknown)

_____ Any Current/Recent Injuries

If yes, Please list _____

_____ Childhood Illness

_____ Rheumatic Fever / Rheumatic Heart Disease

_____ Blood Transfusion

_____ Congenital Heart Disease or Hearth Murmur

_____ Any Prolonged Bleeding/Bruises Easily

If yes, Premed Needed? _____

_____ Kidney or Bladder Problems

Name of Pharmacy: _____

_____ Tuberculosis or Pneumonia

Pharmacy Phone Number: _____

_____ Liver Problems, Jaundice or Hepatitis

_____ Glandular or Hormonal Problems

_____ Accidents or Severe Infections

_____ Diabetes/Blood Sugar Problems

_____ Psychological or Emotional Problems

_____ Arthritis or Rheumatism (painful, swollen joints)

_____ Any Pending/Recent Surgery

_____ Convulsions, Seizures, Fainting or Epilepsy

_____ Speech, Learning, or Hearing Disorders

_____ Anemia or Blood Disorders

_____ ADD/ADHD

_____ High/Low Blood Pressure

_____ Autism

_____ Asthma or Hay Fever (Please Indicate) If yes, please list any current medications _____

Are your child's Immunizations Current? _____

Please explain any other medical concerns/Current Medication(s): _____

Dental History

Date of Last Dental Visit _____ By Dr. _____

Do you have any Current Records (including x-rays) from another practice? Yes No

Has your child complained about any dental problems? _____

Any injuries or surgeries to mouth, teeth, head? Yes No If yes, please describe: _____

Does your child still take the bottle or sippy cup? _____

Does your child brush daily? Yes No How Often? _____

Is Dental Floss used? Yes No

Please check each box if your child has any of the following mouth habits

Thumb Sucking Mouth Breathing Pacifier Nail Biting Finger Sucking Grinding Other _____

How does your child receive Fluoride?

Water Supply Dentist Toothpaste Vitamins Tablets None

Other: _____

Child's Attitude Towards Dentistry: _____

Reason for Today's Visit/Chief Concerns: _____

Authorizations

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

(Signature of Parent/Guardian)

(Date)

I certify that my minor/child is covered by insurance with _____

(Name of Insurance Company)

And assign directly to Rainbow Kids Dental (Dr.Lee) all insurance benefits, if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electronic.

(Signature of Parent/Guardian)

(Date)