# Welcome!

Today's Date:_____

## YOUR CHILD'S INFORMATION

Name:_____ Prefers to be called: _____

Address:_____City:_____State:_____Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____ Date of Birth:_____

Social Security Number:_____ Other immediate family members seen by us:_____

Whom may we thank for referring you? _____

Family Member or Neighbor not living with you:_____ Relation:_____

Phone (_____)_____ We will only use this contact if your phone numbers change and we are unable to reach you.

## PARENT'S/ GUARDIAN'S INFORMATION

Who makes the appointments?_____

Mother's Name:_____ Date of Birth:_____ SSN:_____

Employer_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

Email Address_____

Father's Name:_____ Date of Birth:_____ SSN:_____

Employer_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

Email Address_____

Who is the best contact for making appointments and sending appointment reminders?_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

You may send me appointment reminders through ☐ Text Messages ☐ Email ☐ Phone Calls Only

## RESPONSIBLE PARTY

Name:_____ Relationship to Patient: _____

Billing Address (if different than above):_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ext.____ Cell Phone (_____)_____

Date of Birth:_____ DL:_____ SSN:_____

**Dental Care of Flora, PLLC - Brad A. Franklin, DMD**
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p. 601-879-0031 – f. 601-879-8474

## DENTAL INSURANCE

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (___)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE A SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (___)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

## YOUR CHILD'S MEDICAL HISTORY

Is your child currently being treated by a physician? ☐ Yes ☐ No Reason:_____

Please list **all** medications your child is taking:_____

Is your child pregnant or nursing at this time? ☐ Yes ☐ No Does your child have any metal rods, implants or pins? ☐ Yes ☐ No

Please answer each question. **HAS YOUR CHILD HAD OR HAVE ANY OF THE FOLLOWING?** (Please place an "X")

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abnormal Bleeding | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Pacemaker |
| ☐ | ☐ | ADD/ ADHD | ☐ | ☐ | Heart Surgery | ☐ | ☐ | Psychiatric Problems |
| ☐ | ☐ | Anemia | ☐ | ☐ | Hemophilia | ☐ | ☐ | Radiation Treatment |
| ☐ | ☐ | Any Operations | ☐ | ☐ | Hepatitis ___ | ☐ | ☐ | Rheumatic/Scarlet Fever |
| ☐ | ☐ | Artificial Bones/Joints/Valves | ☐ | ☐ | Herpes / Fever Blisters | ☐ | ☐ | Sickle Cell Disease/ Traits |
| ☐ | ☐ | Cancer/ Chemotherapy | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Sinus Problems |
| ☐ | ☐ | Colitis | ☐ | ☐ | HIV+ / AIDS | ☐ | ☐ | Tuberculosis (TB) |
| ☐ | ☐ | Congenital Heart Defect | ☐ | ☐ | Hospitalized for Any Reason | | | |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Kidney Problems | | | |
| ☐ | ☐ | Difficulty Breathing/ Asthma | ☐ | ☐ | Liver Disease | | | |
| ☐ | ☐ | Epilepsy/ Seizures | ☐ | ☐ | Low Blood Pressure | | | |
| ☐ | ☐ | Fainting Spells | ☐ | ☐ | Lupus | | | |
| ☐ | ☐ | Hearing Impairment | ☐ | ☐ | Mitral Valve Prolapse | | | |

Other Medical Condition(s):_____

**Is your child allergic to any of the following?** (Please place an "X")

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Aspirin | ☐ | ☐ | Erythromycin | ☐ | ☐ | Tetracycline |
| ☐ | ☐ | Codeine | ☐ | ☐ | Latex | ☐ | ☐ | Other:_____ |
| ☐ | ☐ | Dental Anesthetics | ☐ | ☐ | Penicillin | | | _____ |

**I have completed this form to the best of my knowledge and I understand it is my responsibility to notify this office of any changes. I also understand that this information will be held in the strictest confidence. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.** Patient Signature:_____Date:_____

## YOUR CHILD'S DENTAL HISTORY

Previous Dentist:_____ Most recent Dental Exam:_____

Most recent Dental Treatment (When & What):_____ Most recent Dental X-ray:_____

How often do you have your teeth cleaned?: _____3mo. _____4mo. _____ 6mo. _____ 12mo. _____ Never

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

**WHAT IS YOUR REASON FOR COMING TODAY?** _____

**Does your child experience any of the following?**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Bleeding gums while brushing or flossing |
| ☐ | ☐ | Sensitivity to hot/ cold / sweets? |
| ☐ | ☐ | Sore teeth or gums |
| ☐ | ☐ | Dry mouth |
| ☐ | ☐ | An unpleasant taste or odor in his/her mouth |
| ☐ | ☐ | Jaw problems: TMJ, clicking, popping |
| ☐ | ☐ | Have you lost any teeth. If yes, why? _____ |
| ☐ | ☐ | Problems with any previous dental treatment/ anesthetics |
| ☐ | ☐ | Speech problems |
| ☐ | ☐ | Thumb sucking |
| ☐ | ☐ | Clenching / Grinding teeth |
| ☐ | ☐ | Nursing Bottle Habits (i.e. going to sleep with bottle or sippy cup) |
| ☐ | ☐ | Does your child play contact sports? |
| ☐ | ☐ | Orthodontic Treatment (Braces) When?_____ Provider?_____ |
| ☐ | ☐ | Is your child unhappy with the appearance of their teeth? If yes, check below all that apply. |

☐ Color of Teeth ☐ Crowding ☐ Spaces ☐ Other:_____

## PAYMENT NOTICE

**PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.**

I understand that this office accepts and files insurance as a convenience to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that I am responsible for payment in full if my insurance company denies or delays making payments in a timely manner. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

Parent or Guardian Signature:_____ Date:_____