Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Name of minor/child _____ _____
First Name Middle Initial Last Name Nickname

Sex □ M □ F Age ____ Date of Birth _____ Soc. Sec. #_____ Hobbies _____

Address _____ City _____ State ____ Zip Code _____

Person Financially Responsible for Account _____

Whom may we thank for referring you? _____

Parent Information

Father's/Guardian's Name _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from minor/child's) _____

City _____ State ____ Zip Code _____ Phone # _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Name of Employer _____

Do you have dental insurance coverage for minor/child? □ Yes □ No

Insurance Company _____

Group # _____ Subscriber # _____

Mother's/Guardian's Name _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from minor/child's) _____

City _____ State ____ Zip Code _____ Phone # _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Name of Employer _____

Do you have dental insurance coverage for minor/child? □ Yes □ No

Insurance Company _____

Group # _____ Subscriber # _____ → **(over)**

Dental History

Is this the first visit to a dental office for minor/child? □ Yes □ No

If no, name of previous dental office _____

Date of last visit dental visit _____ Date of last dental x-rays _____

Has minor/child complained about dental problems? □ Yes □ No If yes, please explain: _____

_____

Any unhappy dental experiences? □ Yes □ No If yes, please explain: _____

_____

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

_____

Any mouth habits – thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc? □ Yes □ No

If yes, please explain: _____

Any unusual speech habits? □ Yes □ No If yes, please explain: _____

Any orthodontic appliances worn now or in the past? □ Yes □ No

How often does minor/child brush teeth? _____ Do you assist minor/child with tooth brushing? □ Yes □ No

How often does minor/child floss? _____ Do you assist minor/child with flossing? □ Yes □ No

Does minor/child receive fluoride in any form? □ Yes □ No

Does minor/child grind or clench their teeth? □ Yes □ No

What is minor's/child's attitude towards dentistry? _____

Emergency Contact

In the event of an emergency, whom should we contact?

Name _____ Relationship to minor/child _____ Phone # _____

Name _____ Relationship to minor/child _____ Phone # _____

We are happy to help you submit the necessary insurance forms; however, we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask that all patients be responsible for all charges.

I hereby authorize payment of my insurance benefits directly to Jeremy Berger DDS PLLC (DBA Bluffside Dental). I accept this attending dentist's statement and authorize release of information relating hereto.

I understand that I am financially responsible for all charges whether or not paid by insurance. All accounts over 60 days will be charged 1.5 % interest monthly.

Signature _____ **Date** _____

Payment is due in full at time of treatment unless prior arrangements have been approved.