Agape Dental Group
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WELCOME

We are please 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'll be glad to help you.
We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date ____________ SSHIC/Patient ID # ____________ Birthdate ____________

Name of Minor/Child ____________ Sex ☐ M ☐ F Age ____________
(Last Name) (First Name) (Middle Initial)

Nickname ____________ Cell Phone ( ) ____________

Home Address ____________
Street City State Zip

Home Phone ( ) ____________ Work Phone ( ) ____________

School Name ____________

Whom may we thank for referring you? ____________

INSURANCE

Father's/Guardian's Name ____________

Home Phone ____________

Work Phone ____________

E-Mail ____________

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

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

Plan Name ____________ Phone ____________

Address ____________

Group # ____________ Policy # ____________

Mother's/Guardian's Name ____________

Home Phone ____________

Work Phone ____________

E-Mail ____________

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

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

Plan Name ____________ Phone ____________

Address ____________

Group # ____________ Policy # ____________

Is your child eligible for treatment under Medical Assistance? ☐Yes ☐No Child's Medical Assistance I. D. # ____________

DENTAL HISTORY

Date of last visit to a dentist ____________ For what service? ____________

	Yes	No
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss daily?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician ______________________ City/State ______________________ Phone ______________

Date of last physical examination ______________________ Results ______________________

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding with cut?	☐	☐

Medications ______________________

____

____

Allergies ______________________

____

Has minor/child had nay history or difficulty with any of the following? If yes, please check (✓)

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Cerebral Palsy	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Chicken Pox	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Hearing Problems	☐	☐	Measles	☐	☐	Thyroid Disease
☐	☐	Bladder Problems	☐	☐	Diabetes	☐	☐	Heart Problems	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Drug/Alcohol Abuse	☐	☐	Hepatitis	☐	☐	Mumps	☐	☐	Other

EMERGENCY CONTACT

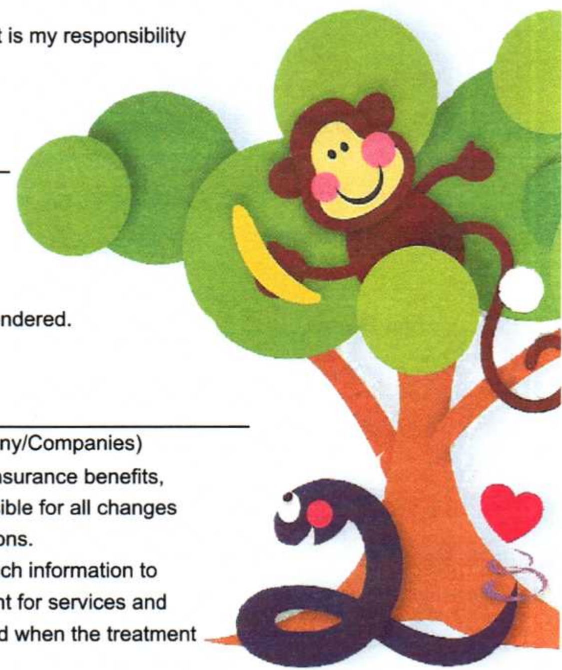
In the event of an emergency, whom should we contact?

Name ______________________ Relationship ______________________ Phone ______________

Name ______________________ Relationship ______________________ Phone ______________

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor/child ever has a change in health.



Minor/Child Consent

I am the parent, guardian, or personal representative of ______________________
(Please Print Name of Minor/Child)

and there are not court orders now in effect that prohibit me from signing this consent.
I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ______________________
(Name of Insurance Company/Companies)

and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the treatment plan is completed or one year from the date signed below.

______________________ Signature of Parent, Guardian, or Personal Representative ______________ Date

______________________ Please print name of Parent, Guardian, or Personal Representative ______________ Relationship to Patient

HIPPA

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

______________ Signature of Patient/Parent/Conservator ______________ Please Print Name ______________ Date