

Child Patient's Information

Child's Name: _____ Birth Date: _____ Male Female
Last First MI
Address: _____ Apartment # _____
Street

City State Zip Code
School _____ City _____ State _____ Full Time? _____

Parent(s) Information

Father's Name: _____ Married Single Other
Last First MI
Birth Date: _____ **Social Security #:** _____ **Driver's License #:** _____
Phone Home: (____) _____ **Work:** (____) _____ **Ext:** _____
E-mail address: _____
Home Address: _____
Street Apartment # _____
City State Zip Code
Father's Employer: _____ **Position:** _____
Mother's Name: _____ Married Single Other
Last First MI
Birth Date: _____ **Social Security #:** _____ **Driver's License #:** _____
Phone Home: (____) _____ **Work:** (____) _____ **Ext:** _____
E-mail address: _____
Home Address: _____
Street Apartment # _____
City State Zip Code
Mother's Employer: _____ **Position:** _____

Nearest Relative Not Living With Child

Name: _____ **Phone Home:** (____) _____ **Relationship** _____
Last First MI
Address: _____
Street Apartment # _____
City State Zip Code

Insurance Information

Primary
Name of Insured: _____ **Is insured a patient?** Yes No
Last First MI
Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____
Insurance Plan Name and Address: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Secondary
Name of Insured: _____ **Is insured a patient?** Yes No
Last First MI
Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____
Insurance Plan Name and Address: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Has child had any history of the following? Please check those that apply:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Problems | |

- Has child ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Has child been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Is child now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: (____) _____
- Does child have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Is there now or has there been any of the following?: cavities pain broken tooth extracted tooth braces gum infection

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Sign Date: _____

Child's Interest and Hobbies

State child's interest and hobbies: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Are other family members a patient here?: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Sara T. Truong, D.D.S., agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand ALL BOUNCED CHECKS WILL BE CHARGED UP TO TWO TIMES THE CHECK AMOUNT. I also understand if my account is forced to be sent to collections for non payment, I will be charged up to two times the amount of my balance.

I grant my permission to Sara T. Truong, D.D.S. or her assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian/ guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

Help us get to know you

When I think about coming to the dentist I feel

- comfortable
- anxious
- fearful
- extremely fearful

I have avoided the dentist because of

- my anxiety and fear
- past experiences
- cost
- no time
- lack of trust
- other _____

My childhood dental experiences were

- completely pain free and comfortable
- somewhat uncomfortable
- painful
- traumatic
- I did not go to the dentist as a child

My dental experiences as an adult have been

- completely pain free and comfortable
- somewhat uncomfortable
- painful
- traumatic
- I have not seen the dentist as an adult or my visits have been very few

I have fear of-I have concerns about

- experiencing pain
- not being numb
- needles
- unnecessary or wrong treatment
- gagging
- losing control
- having something put over my mouth
- being scolded or made to feel ashamed
- catching a disease
- losing my teeth
- having to wear a denture or partial
- other _____

The following makes me uncomfortable

- the sounds of a dental drill
- laying down in a dental chair
- the smells in a dental office
- being numb
- having to wait in the reception area
- other _____

To understand what's going on in my mouth, my preference is

- to know all the details
- to be given the bottom line
- to be shown pictures and movies
- to read pamphlets and brochures
- to talk with a team member about solutions to my problems

My immediate concern about my teeth and smile is
