MORRISON DENTAL ASSOCIATES
www.mdadental.com

Child

Welcome. The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate the better we can care for you.

Child's Name _____
Last First Middle

Nickname _____ Date of Birth _____

Special Interest (pets, sports, hobbies, etc.) _____

_____

Parent or Guardian Information

Parent or Guardian Name _____
Last First Middle

Social Security Number _____ Date of Birth _____

____ Married ____ Single ____ Divorced ____ Widowed

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Employer _____ Employer Phone _____

Employer Address _____

City _____ State _____ Zip _____

In the event of an emergency who should we contact? _____

Relationship _____ Phone Number _____

Mailing address IF DIFFERENT _____

City _____ State _____ Zip _____

Child's Medical History

Does your child have a physician? Yes ____ No ____

May we have permission to contact your child's physician if necessary? Yes ____ No ____

Physician's Name _____ Phone Number _____

Approximate date of your child's last visit with physician _____

Is your child currently under the care of a physician? _____ If yes, explain _____

_____

Is your child presently taking any drugs prescribed by a physician or other practitioner? Yes ____ No ____

Please list _____

For females – Is your child pregnant? Yes ____ No ____ Week # _____

Has your child had any serious medical problems in the past 5 years? Yes ____ No ____

Please explain _____

Is your child **ALLERGIC** to any of the following? **PLEASE CIRCLE**

Y	N	Penicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Sulfa Drugs	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Other
Y	N	Latex	Y	N	

Please list _____

Does your child have any of the following disease or medical problems? **PLEASE CIRCLE**

Y	N	Heart Attack / Stroke	Y	N	Cancer / Chemotherapy
Y	N	Heart Murmur / Rheumatic Fever	Y	N	HIV+ / AIDS
Y	N	Heart Surgery / Pace Maker	Y	N	Shingles
Y	N	Hepatitis	Y	N	Kidney Problems
Y	N	Anemia	Y	N	Sinus Problems
Y	N	High Blood Pressure	Y	N	Fever Blisters
Y	N	Low Blood Pressure	Y	N	Psychiatric Problems
Y	N	Epilepsy / Seizures / Fainting	Y	N	Diabetes
Y	N	Drug / Alcohol Abuse	Y	N	Tuberculosis TB
Y	N	Hemophilia / Abnormal Bleeding	Y	N	Sickle Cell Disease
Y	N	Severe Headaches	Y	N	Other

If yes on Other, please explain _____

Child's Dental History

Why has your child come in today? _____

Is this your child's first dentist visit? Yes ____ No ____ Is your child currently in pain? Yes ____ No ____

Does your child grind his/her teeth? Yes ____ No ____

Does your child experience stress or anxiety when visiting the dentist? Yes ____ No ____

Has your child brushed his/her teeth today? Yes ____ No ____

Child's current dental health is **good** ____ **fair** ____ **poor** ____

Does your child like to smile? Yes ____ No ____ Do his/her gums bleed? Yes ____ No ____

Who was your child's previous dentist? _____

Who referred you to us? _____

I the undersigned, do hereby authorize Morrison Dental Associates, PC to exam and treat the patient as deemed necessary by the dentist. If the undersigned is not the patient, he/she assumes all responsibility for the accurateness of the medical and dental information furnished on this form. I further affirm that the medical and dental information is correct and the patient does not have any communicable disease which would be infectious to those providing services for him/her or others coming in contact with the patient in the office. This authorization is good for two years.

Patient or Guardian Date

If the information on the first form does not belong to the person signing the form above, please fill out the following:

Print Name of Signer Relationship to patient

Address of Signer City State Zip

Home Phone Number Employer of Signer

Employer's Address Employer's Phone Number

If you wish to file dental insurance or Medicaid please tell the receptionist so we can obtain the information necessary to file for you. The undersigned understands that insurance or Medicaid coverage does not relieve him/her of the responsibility of payments of the entire account if third party payment is not received. Estimates given by our staff are not a guarantee of the insurance or Medicaid payments as these third parties will not guarantee payments until a claim is received. Estimates are based on information we have at the time regarding your coverage. The undersigned is responsible for the payment of services rendered in addition to the head of household. If the patient is a minor BOTH parents are responsible. If the undersigned is not the patient it is understood that the patient is also responsible for payment of services provided for him/her.

In event of non-payment resulting in default of the account should Morrison Dental Associates, PC refer this account to an attorney, I agree to pay and indemnify Morrison Dental Associates, PC against legal cost and charges including, but not limited to, reasonable attorney's fees, court cost and disbursements. I further grant permission to release information contained on this information sheet to any attorney in order to collect the amount due. Interest shall accrue on the account at the rate of 1.5% per month, 18% annum, on the unpaid balance. Payment in-full is due at the time of service unless written arrangements are made in advance of treatment. Any account not paid at the time of service is due in-full within thirty (30) days of services. If account is not paid at the time of service, Morrison Dental Associates, PC is authorized to obtain a report from a credit reporting agency regarding my credit history.

PLEASE GIVE THE RECEPTIONIST A PHOTO IDENTIFICATION CARD when you return this form.

Patient / Parent or Guardian Date

Social Security Number _____

***** Member Equifax Credit Reporting Services *****

As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations.