Welcome. Thank you for choosing the office of Dr. W. Scott White for your family's dental health care needs. If we can be of any assistance to you in completing these forms, please do not hesitate to ask. Our team is committed to your child's treatment being both a pleasant and successful experience. Please let us know if there is anything we can do to make their visit with us as comfortable as possible.

CHILD PATIENT INFORMATION

Name: _____ Date: _____
First Middle Last Child's Preferred Name

Social Security #: _____ Gender: Male Female Birth Date: _____

PARENT/GUARDIAN ACCOMPANYING CHILD

Are you a patient? ☐ Yes ☐ No

Name: _____ Date: _____
First Middle Last Your Preferred Name

Please circle: Married Single Divorced Widowed Gender: Male Female Birth Date: _____

Driver's License #: _____ Social Security #: _____ E-mail: _____

Phone: Home: _____ Work: _____ Cell: _____

Preferred Method of Contact (please circle): Home Phone Work Phone Cell Phone E-mail Text

Physical Address: _____
Street Suite/Apartment # City State Zip

Mailing Address: _____
(if different than above) Street Suite/Apartment # City State Zip

Employer Name: _____ Occupation: _____

ADDITIONAL PARENT/GUARDIAN INFORMATION

Are they a patient? ☐ Yes ☐ No

Name: _____ Birth Date: _____
First Middle Last Preferred Name

Social Security #: _____ Phone: Work: _____ Cell: _____

Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT US?

Please Circle: Friend Relative Dentist Internet Yellow Pages Sign Other

Name of referral source (which friend, relative, phone book, website, etc.) _____

INSURANCE INFORMATION

Primary Dental Insurance

Who is the insured? _____ Relationship to child: Parent Guardian Other: _____

ID #: _____ Group #: _____ Insurance Plan Phone #: _____

Insurance Plan Name and Address: _____

Secondary Dental Insurance

Who is the insured? _____ Relationship to child: Parent Guardian Other: _____

ID #: _____ Group #: _____ Insurance Plan Phone #: _____

Insurance Plan Name and Address: _____

Regarding Scheduled Appointments: We respect your time and do not "double-book" appointments. **When you schedule an appointment with us, this time is reserved exclusively for you.** Any change in this appointment affects many people. If you are unable to keep your appointment, please give us as much notice as possible, preferably 48 hours, so that we may offer this time to another patient. We may charge up to $25 per half hour that we are unable to use as a result of a broken or cancelled appointment.

Regarding Financial Arrangements: Payment for services rendered is considered part of your child's treatment and is due at the time of service, unless financial arrangements are made prior to treatment. This policy has been instrumental in keeping dental care costs down for our patients by eliminating the costly administrative expenses associated with billing procedures. Patients will incur a $25 charge for each returned check**.** Any balance left unpaid for more than 30 days will be subject to interest charges at the rate of 1.5% per month.

We accept the following methods of payment:

Cash, Check, Money Order, Visa, MasterCard, Discover, American Express
Extended payment plans: Care Credit and Lending Club (Please ask for details)

Regarding Insurance: If you like, we will be happy to assist you in filing your insurance. This is a special service we provide for our patients to help eliminate some of the often confusing paperwork associated with processing claim forms. **Please remember your insurance policy is a contract between you and your insurance company.** Our office is not a party to the contract. We will do our best to estimate your portion of the fee and help you utilize your insurance benefits. However, you will be responsible for any amount unpaid by your insurance company.

Please be aware that some treatments provided may not be considered customary by your insurance carrier and may be labeled "non-covered" or "plan exclusion" under your particular plan according to each individuals policy. Through the years our office has learned the level of coverage of any dental plan is directly related to the level of payment made to the plan by the policy holder's employer.

Thank you for your understanding of our Financial Policy. Please let us know if you have questions. We reserve the right to modify these policies at any time without further notice.

Acknowledgement of Notice of Privacy Practices – I have had a copy of this office's Notice of Privacy Practices made available to me to read. I also understand that I can request to receive a copy of this Notice for my records at any time.

Consent for Services

I consent to the performing of dental procedures for my child deemed to be necessary by the doctor. To the best of my knowledge this paperwork has been accurately answered. I will bring all future changes in my child's medical history to the attention of the doctor. I understand that providing incorrect or incomplete information can be dangerous to my child's health. I grant my permission to you or your assignee, to telephone me at home, by cell, at my work, or to send text messages or emails, to discuss matters related to this form and my child's oral health. **Minor children must be accompanied by a parent or legal guardian to all appointments, unless discussed in advance with our office.** I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension of the proposed procedure or a change from what was previously noted. If that occurs, I authorize the doctor and staff to perform such procedures as necessary and desirable in the exercise of professional judgment and I will be responsible for any associated fees. I authorize my insurance benefits to be paid directly to Dr. White's office. **I understand and agree to the above conditions of treatment, the Notice of Privacy Practices, and the office Financial Policies and will be responsible for payment for my child's treatment.** I authorize the doctor to release any and all photographs taken of the previously named patient for teaching purposes, for educational journals, and for marketing purposes.

Signature: _____ Date: _____

CHILD'S MEDICAL HISTORY

Patient Name _____ Age _____ Date _____

Name of Physician _____ Physician Phone # _____

Date of last visit to physician _____ Rate your child's general health: Poor _____ Fair _____ Good _____

PLEASE CHECK YES OR NO FOR THE FOLLOWING

YES	NO	Allergic reaction to:
☐	☐	aspirin, ibuprofen, acetaminophen
☐	☐	penicillin
☐	☐	erythromycin
☐	☐	codeine
☐	☐	local anesthetic
☐	☐	latex
☐	☐	metals (gold, stainless steel)
☐	☐	any other medications

_____

☐	☐	Hospitalization for illness or injury
☐	☐	Artificial heart valve
☐	☐	Artificial Joints
☐	☐	Implants
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Heart problems (murmurs, etc.)
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Chest pains / angina
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Low blood pressure
☐	☐	Dizziness or fainting
☐	☐	Pacemaker
☐	☐	Anemia / bleeding disorder
☐	☐	Prolonged bleeding due to a slight cut
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Asthma
☐	☐	Respiratory problems
☐	☐	Sinus problems
☐	☐	Hay fever, hives, skin rash
☐	☐	Kidney disease
☐	☐	Liver Disease
☐	☐	Jaundice
☐	☐	Thyroid or parathyroid problems

YES	NO	
☐	☐	Hormone / endocrine problems
☐	☐	Diabetes
☐	☐	High Cholesterol
☐	☐	Stomach / digestive problems
☐	☐	Ulcers
☐	☐	Arthritis
☐	☐	Rheumatism
☐	☐	Glaucoma
☐	☐	Head or neck injury
☐	☐	Epilepsy / seizures
☐	☐	Venereal disease / STD
☐	☐	Hepatitis (type _____)
☐	☐	AIDS/HIV
☐	☐	Tumor or abnormal growth
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Mood disorder / emotional problems
☐	☐	Nervous disorder
☐	☐	Psychiatric treatment
☐	☐	Antidepressant medication
☐	☐	Alcohol or drug dependency

IS YOUR CHILD:

☐	☐	Presently being treated for any illness
☐	☐	Aware of a change in their general health
☐	☐	Often exhausted or fatigued
☐	☐	A tobacco user

Type _____
Amount / frequency _____
Do you want to quit _____

☐	☐	Considered a touchy person
☐	☐	Often unhappy or depressed
☐	☐	Easily upset or irritated
☐	☐	FEMALE - taking birth control pills
☐	☐	FEMALE – pregnant

Please describe any current medical treatment or impending surgery that may affect your child's dental treatment: _____

_____

List any **medications**, **vitamins**, **herbal supplements**, or **dietary supplements** your child is currently taking: _____

_____

_____

Is your child currently taking or have they previously taken any of the following medications: YES ☐ NO ☐

Coumadin/Warfarin Plavix Fen-phen/Redux/Pondimin Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia)

PLEASE ADVISE US OF ANY FUTURE CHANGES IN YOUR CHILD'S MEDICAL HISTORY OR MEDICATIONS.

Parent/Guardian's Signature _____ Doctor's Signature _____

CHILD DENTAL HISTORY

Child's Name _____ Age _____

Previous Dentist _____ How long ago was their last visit _____

WHAT IS YOUR CHILD'S IMMEDIATE DENTAL CONCERN ? _____

_____

How often does your child brush their teeth? ☐ once a day or less ☐ twice a day ☐ more than twice a day

How long does your child spend brushing their teeth each time they brush? ☐ less than 2 mins. ☐ 2 mins. or longer

How often does your child floss their teeth? ☐ never ☐ rarely ☐ once a day ☐ more than once a day

Do you supervise / assist your child with brushing / flossing? ☐ Yes ☐ No

How many sodas, sports drinks, or energy drinks does you child drink a day? ☐ none ☐ one ☐ more #:_____

YES NO PLEASE CHECK YES OR NO FOR THE FOLLOWING:

☐ ☐ Is your child self conscious or concerned about the appearance of their teeth?

☐ ☐ Would you like us to discuss proper brushing and flossing with your child?

☐ ☐ Does your child have sensitive or sore teeth?

☐ ☐ Does your child have bleeding gums?

☐ ☐ Does your child have an unpleasant taste or odor in their mouth?

☐ ☐ Has your child previously had orthodontic treatment (braces) or an orthodontic evaluation?

If Yes, who was the doctor? _____

If No, have either parent or any siblings recently had orthodontic treatment? ☐ Yes ☐ No

If Yes, who was the doctor? _____

☐ ☐ Does your child currently wear any type of appliance (retainer, nightguard, sports mouthguard, etc.)?

If yes, what type of appliance? _____

☐ ☐ Does your child have jaw problems (TMJ problems)?

☐ ☐ Does your child have jaw clicking or popping?

☐ ☐ Does your child's jaw ever lock?

☐ ☐ Does your child have difficulty opening their mouth widely?

☐ ☐ Does your child have tension headaches?

☐ ☐ Are you or your child aware of any clenching or grinding of their teeth?

☐ ☐ Has your child had any unfavorable previous dental experiences?

If yes, please discuss this privately with Dr. White.

☐ ☐ Does your child have anxiety about dental visits?

☐ ☐ Does your child have any lumps or swelling in their mouth?

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

☐ My child goes to bed with a bottle.

☐ My child uses a pacifier.

☐ My child uses a sippy cup.

☐ My child sucks their thumb or fingers.

Patient's Signature _____ Doctor's Signature _____