JONES
DENTAL CARE

CHILD FORM

Welcome! We want you to know that we will do our very best to provide you with the most pleasant dental experience possible. To help us in this we need to have both the front and back sides of this form filled out with as much detail as possible. We pride ourselves in our accuracy and our attention to detail, and it makes our jobs easier if we can get all of your child's information charted properly. Thank you for your patience. Sincerely, Dr. Ammon Jones and Dr. Aaron Jones

PATIENT INFO

_____ name (first, mi, last)
_____ preferred Name

male [ ] female [ ]
_____ birth date (m / d / y)
(_____) _____ - _____ home phone

_____ address (street/apt)
_____ city
_____ state
_____ zip code

FATHER INFO

_____ name (first, mi, last)
_____ preferred Name

_____ birth date (m / d / y)
_____ social security number
(_____) _____ - _____ cell phone

_____ address (if different)
_____ city
_____ state
_____ zip code

MOTHER INFO

_____ name (first, mi, last)
_____ preferred Name

_____ birth date (m / d / y)
_____ social security number
(_____) _____ - _____ cell phone

_____ address (if different)
_____ city
_____ state
_____ zip code

HEALTH INFO

[ ] ALLERGIES: (please list)
_____
[ ] ASTHMA
[ ] BLEEDING DISORDER
[ ] CODEINE ALLERGY
[ ] EPILEPSY
[ ] HEAD/JAW INJURY
[ ] HEART DISEASE
[ ] HEART MURMUR
[ ] PENICILLIN ALLERGY
[ ] RHEUMATIC FEVER
[ ] SINUS PROBLEMS

Please list any other health issue that could affect your child's dental treatment:

_____

If your child is currently being treated by a physician who we may need to consult please explain and give his/her name & office number:

_____

Please detail any unusual complication or reaction your child may have had in previous dental treatment:

_____

_____

Is your child particularly anxious about dental appointments or dental work?

_____

Are you comfortable if at future appointments we use Nitrous Oxide (laughing gas) for a minimal charge to make the dental experience more pleasant for him/her?

_____

BY SIGNING BELOW I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS ACCURATE AND CORRECT. IF ANY OF THE ABOVE INFORMATION INCLUDING THE HEALTH HISTORY CHANGES IN THE FUTURE, I WILL INFORM THE STAFF OF THIS OFFICE.

X _____ signature
_____ date

CONTINUED

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EMPLOYMENT INFO

FATHER

EMPLOYER NAME (FOR THE PATIENT) _____ WORK PHONE _____

ADDRESS (STREET/APT) _____ CITY _____ STATE _____ ZIP CODE _____

MOTHER

EMPLOYER NAME (FOR THE PATIENT) _____ WORK PHONE _____

ADDRESS (STREET/APT) _____ CITY _____ STATE _____ ZIP CODE _____

INSURANCE INFO

PRIMARY INSURANCE: PATIENT'S RELATIONSHIP TO INSURED: CHILD [ ] OTHER [ ]

NAME OF INSURED _____ INSURED'S BIRTH DATE (D / M / Y) _____

SSN OR SUBSCRIBER ID _____ GROUP NUMBER _____

INSURED'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

INSURED'S EMPLOYER NAME _____ INSURANCE PHONE NUMBER _____

INSURANCE CO. NAME AND ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SECONDARY INSURANCE: PATIENT'S RELATIONSHIP TO INSURED: CHILD [ ] OTHER [ ]

NAME OF INSURED _____ INSURED'S BIRTH DATE (D / M / Y) _____

SSN OR SUBSCRIBER ID _____ GROUP NUMBER _____

INSURED'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

INSURED'S EMPLOYER NAME _____ INSURANCE PHONENUMBER _____

INSURANCE CO. NAME AND ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

CONSENT TO EXAMINE & PROVIDE TREATMENT

AS A CONDITION OF TREATMENT BY THIS OFFICE I GIVE CONSENT TO THE DOCTORS AND STAFF OF JONES DENTAL CARE TO EXAMINE AND DIAGNOSES MY CHILD'S TEETH AND MOUTH AND TO PROVIDE TREATMENT WITH MY VERBAL APPROVAL.

X _____ _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE RELATIONSHIP TO PATIENT