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. It makes our job 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, if different

Preferred Method of contact for appointment reminders (please check one):
[ ] Mom's cell phone [ ] dad's cell phone [ ] home phone [ ] email_____

Gender: Male [ ] female [ ]

_____
Patient Birth date (m/d/y)

_____
Address (street/apt) city state zip code

FATHER INFO

_____ _____
name (first, mi, last) preferred name, if different

_____ _____
Birth date (m/d/y) social security number

(_____)_____ (_____)_____ (_____)_____
cell phone Work phone Home (Land line) phone

_____
Address (if different) city state zip code

MOTHER INFO

_____ _____
name (first, mi, last) preferred name, if different

_____ _____
Birth date (m/d/y) social security number

(_____)_____ (_____)_____ (_____)_____
cell phone Work phone Home (Land line) phone

_____
Address (if different) city state zip code

PATIENT'S HEALTH INFO

[ ] allergies: (please list) [ ] bleeding disorder [ ] head/jaw injury [ ] penicillin allergy
_____ [ ] codeine allergy [ ] heart disease [ ] rheumatic fever
[ ] asthma [ ] epilepsy [ ] heart murmur [ ] sinus problem

Is your child currently on any medication(s)? if yes, please list:
_____

Please list any other health issues that affect your child's dental treatment:
_____

If your child is currently being treated by a physician whom 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 to 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 of parent or guardian date relationship to patient

CHILD FORM

EMPLOYMENT INFO

FATHER INFO

Employer name _____ work phone _____

Address (street/apt) _____ city _____ state _____ zip _____

MOTHER INFO

Employer name _____ work phone _____

Address (street/apt) _____ city _____ state _____ zip _____

DENTAL INSURANCE INFO

Primary insurance: patient's relationship to insured: [ ] child [ ] other

Name of insured _____ insured's birth date (m/d/y) _____

Ssn or subscriber id _____ group number _____

Insured's employer name _____ insurance phone number _____

Insurance co. name and address _____ city _____ state _____ zip code _____

Insured's address (if different than patient's) _____ city _____ state _____ zip code _____

secondary insurance: patient's relationship to insured: [ ] child [ ] other

Name of insured _____ insured's birth date (m/d/y) _____

Ssn or subscriber id _____ group number _____

Insured's employer name _____ insurance phone number _____

Insurance co. name and address _____ city _____ state _____ zip code _____

Insured's address (if different than patient's) _____ 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 diagnose my child's teeth and mouth and to provide treatment with my verbal approval.

X _____

Signature of parent or guardian date relationship to patient

REFERRAL INFO

We love to reward those who refer others to our practice. Send in a friend and we'll send you a gift!

Who may we thank for referring you to our practice?

X _____