StarRanch
FAMILY DENTAL

ABOUT YOUR CHILD

Child's Name ____________________ Preferred Name ____________________

M _____ F _____ Date of Birth ____________________ Age _______ Weight _______ lbs Height _________

School Name ____________________ Name of Pets ____________________

*Primary Email Address ____________________ *We respect your privacy. We do not give out your information. Our office requests email information in order to send appointment reminders, birthday wishes, and newly published dental information.

Referred By: ○ Website ○ Google ○ Insurance ○ Phone Book ○ Other ______________ ○ *Friend/Family _____________

*We have a referral program that benefit our referring patients

How do you describe your child? ○ Shy ○ Outgoing ○ Calm ○ Dramatic ○ Nervous ○ Active ○ Friendly ○ Moody ○ Curious

PARENTS/GUARDIAN/RESPONSIBLE PARTY

Father's Name ____________________ Relationship to Patient ○ Father ○ Stepfather ○ Guardian

Address ____________________

Home Phone ____________________ Mobile Phone ____________________ Work Phone ____________________

Date of Birth ____________________ SS# ____________________

Employer ____________________ Occupation ____________________ Rank (if military)_______

Mother's Name ____________________ Relationship to Patient ○ Mother ○ Stepmother ○ Guardian

Address ____________________

Home Phone ____________________ Mobile Phone ____________________ Work Phone ____________________

Date of Birth ____________________ SS# ____________________

Employer ____________________ Occupation ____________________ Rank (if military)_______

Please rank the best way to confirm appointments (1-4, 1 being the best) Cell ____ Home ____ E-Mail ____ Text ____

RESPONSIBLE PARTY: The permission of parent or guardian is necessary for dental treatment of a minor. I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

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Signature **Date**

____

Signature **Date**

INSURANCE

Name of Insurance Company ____________________ Phone Number ____________________

Billing Address ____________________ Group # ____________________

Policy Holder's Name ____________________ ID# ____________________

*Insurance is a contract between you and your insurance company. SRFD does not have a say in your plan benefits. We will bill your insurance company as a courtesy to you and we will do our best to collect what is rightfully your benefit. Although we may **ESTIMATE** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. It is your responsibility to know your insurance benefits, not ours. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. INSURANCE IS NOT A GUARANTEE OF PAYMENT. YOU AGREE TO PAY ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE. ANY INSURANCE CLAIM THAT HAS NOT BEEN PAID WITHIN 4 WEEKS BECOMES YOUR RESPONSIBILITY FOR PROMPT PAYMENT. TO AVOID THIS, PLEASE MAKE SURE YOU ARE IN CONTACT WITH YOUR INSURANCE COMPANY REGARDING THE UNPAID CLAIMS AFTER 4 WEEKS. WE DO NOT FILE SECONDARY INSURANCE. You agree to notify SRFD of any changes with your dental insurance as soon as possible and NOT the day of your child's appointment.

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DENTAL HISTORY

Is this your child's first dental visit? ○ YES ○ NO Has your child had recent dental pain or swelling? ○ YES ○ NO
Has your child had any accidents involving the teeth or jaws? ○ YES ○ NO If yes, please describe: ______________________

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Previous Dentist ______________________________ City _____________ State ______ Date of Last Dental Visit ____________
Orthodontist ____ Phone Number _________________________

History of: ○ Nursing, bottle habits ○ Thumb sucking/finger ○ Pacifier ○ Dental grinding/clenching ○ Mouth Breathing/Sleep Apnea
Has your child experienced any unfavorable reaction from previous medical or dental care? ○ YES ○ NO
If yes, please explain: ____

ALLERGIES

○ YES ○ NO Medications ______________________________ ○ YES ○ NO Environmental Pollutants _______________________
○ YES ○ NO Latex, metals, acrylics ______________________ ○ YES ○ NO General Anesthesia _____________________________
○ YES ○ NO Food _____________________________________ ○ YES ○ NO Local Anesthesia _______________________________
○ YES ○ NO Dyes _____________________________________ ○ YES ○ NO Codeine _______________________________________
Has any member of the family, including your child, had a problem with a general anesthetic? YES _____ NO _____

MEDICAL HISTORY

Child's Physician ____ Phone Number _________________________
Has your child ever been hospitalized or had surgery? ○ YES ○ NO Reason for hospitalization ___________________________
Are antibiotics necessary for dental work because of a heart murmur/defect/prosthesis/shunt or other medical reason? ○ YES ○ NO
Is your child presently taking medications? ○ YES ○ NO If yes, what medication? _______________________________________

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? PLEASE CHECK EVERY BOX AS YES OR NO

Yes	No		Yes	No		Yes	No		Yes	No	
__	__	Aids/HIV	__	__	Chronic Adenoid/ Tonsil Infection	__	__	Growth/Developmental Problems	__	__	Orthopedic Problems
__	__	Anemia							__	__	Pain in Jaw Joints
__	__	Asthma	__	__	Chronic Ear Infection	__	__	Heart Surgery	__	__	Premature Birth
__	__	Autism	__	__	Cleft Lip/Palate	__	__	Headaches	__	__	Psychiatric Care
__	__	Bladder Conditions	__	__	Congenital Heart Lesion	__	__	Hearing/Speech Impairment	__	__	Radiation
__	__	Blood Disease	__	__	Convulsions/Seizures	__	__	Heart Murmur/Defect	__	__	Rheumatic Fever
__	__	Blood Transfusion	__	__	Developmentally Delayed	__	__	Hemophilia	__	__	Scoliosis
__	__	Birth Defects	__	__	Diabetes	__	__	Hepatitis/Liver Disease	__	__	Sickle Cell Anemia
__	__	Bone/Joint Problem	__	__	Emotional Disturbance	__	__	High Blood Pressure	__	__	Syndrome
__	__	Bruises Easily	__	__	Eye Problem	__	__	Kidney Disease	__	__	Other
__	__	Cancer	__	__	Excessive Bleeding	__	__	Leukemia	__	__	Do you wish to speak to the Doctor privately with a special concern?
__	__	Cerebral Palsy	__	__	Excessive Gagging	__	__	Mental Disability			
__	__	Chemotherapy	__	__	Fainting/Dizziness	__	__	Mouth Sores			
__	__	Child Abuse	__	__	Fever Blisters	__	__	Nutritional Deficiency			

EMERGENCY CONTACT INFORMATION

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Closest Relative/Friend Address Phone Number

PHOTO RELEASE FORM

We love posting and sharing accomplishments of our patients. In order to do so, we need to get your permission. We will only post your child's photo and first name. We will not release any private information such as your child's last name, phone number, address, email address, etc.

☐ I give permission for SRFD to use photos and the first name of my child to post to any related marketing material, including Facebook.

☐ I do not give permission for SRFD to use photos of my child to post to any related marketing material.

Parent Signature ____ Date ______________________