



Michelle H. Edwards, DDS, MSD

www.babytoothcenter.com

**Patient Information**

Child's Full Name \_\_\_\_\_ Name Called By \_\_\_\_\_  
Age \_\_\_\_\_ Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Hm Phone ( ) \_\_\_\_\_  
Child's Favorite Hobbies/Interests \_\_\_\_\_ Name of School/Day Care \_\_\_\_\_  
What grade? \_\_\_\_\_ Siblings (Names & Ages) \_\_\_\_\_  
Child's Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Date of Last Exam \_\_\_\_\_  
What is your Child's Current Weight? \_\_\_\_\_ What is your Child's Current Height? \_\_\_\_\_

**Parent/Guardian Information**

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work/Mobile Phone ( ) \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work/Mobile Phone ( ) \_\_\_\_\_  
Would you like to confirm appointments by e-mail? Yes/No E-mail Address \_\_\_\_\_  
Parent's Marital Status Married / Divorced / Separated / Widowed / Remarried / Single

**Emergency Contact- Friend or Relative Not Living with You**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ Zip Code \_\_\_\_\_

**Insurance/Financial Information and Agreement**

Dental coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No Orthodontic coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
Name of Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

I understand my dental insurance is a contract between the insurance carrier and me; not between Dr. Edwards and the insurance carrier. I agree to be responsible for all charges for dental services and materials not paid by my insurance company. I understand that I will be charged for all dental treatment and that any payments received by Dr. Michelle H Edwards from my insurance carrier will either be credited to my account or refunded back to me if I have paid the fees incurred. To the extent permitted by law, I authorize release of any information relating to claims filed. All co-pays, deductibles and non-covered services will be collected at the time of service. I accept full financial responsibility for the above named patient. If the account is turned over to the collection agency, I will be responsible for all reasonable collection agency fees, reasonable attorney fees, filing fees, court costs and other costs incurred while collecting the principal amount due and owing. All balances over 30 days are subject to a 1.5% per month **finance charge**.

\_\_\_\_\_  
Signature of Guarantor, Insured, Parent, Responsible Party Date \_\_\_\_\_  
Printed Name of Guarantor, Insured, Parent, Responsible Party: \_\_\_\_\_

I hereby authorize payment of the dental benefits otherwise payable directly to Children's Dental Center, LLC  
\_\_\_\_\_  
Signature of Insured Date \_\_\_\_\_

## *Medical History*

**Please indicate with a YES or NO.** Does your child currently have/previously have any of the following health problems?

\_\_\_\_\_ **Allergies (Food, Dust, Drug, Unknown)** If yes, Please List: \_\_\_\_\_

\_\_\_\_\_ **Congenital Heart Disease or Heart Murmur** \_\_\_\_\_ **Rheumatic Fever / Rheumatic Heart Disease**

If yes, Premed needed? \_\_\_\_\_ Name & Phone number of pharmacy \_\_\_\_\_

\_\_\_\_\_ **Asthma or Hay Fever** Please list any current medications \_\_\_\_\_ Last ER visit due to asthma \_\_\_\_\_

\_\_\_\_\_ **Accidents or severe infections** \_\_\_\_\_ **Anemia or Blood Disorders**

\_\_\_\_\_ **Arthritis or Rheumatism (painful, swollen joints)** \_\_\_\_\_ **Blood Transfusion**

\_\_\_\_\_ **Prolonged Bleeding/Bruises easily** \_\_\_\_\_ **Cancer**

\_\_\_\_\_ **Childhood Illnesses** What? \_\_\_\_\_ \_\_\_\_\_ **Cerebral Palsy**

\_\_\_\_\_ **Convulsions, Seizures, Fainting or Epilepsy** \_\_\_\_\_ **Diabetes/Blood sugar problems**

\_\_\_\_\_ **Eating Disorder** What? \_\_\_\_\_ \_\_\_\_\_ **Glandular or Hormonal problems**

\_\_\_\_\_ **High / Low Blood pressure** \_\_\_\_\_ **HIV + / AIDS**

\_\_\_\_\_ **Jaundice / Hepatitis A, B C or liver problems** \_\_\_\_\_ **Kidney or Bladder problems**

\_\_\_\_\_ **Pneumonia or Tuberculosis** \_\_\_\_\_ **Sickle Cell (Carrier or Trait)**

\_\_\_\_\_ **Speech, Learning or Hearings problems** \_\_\_\_\_ **Psychological/Emotional problems**

\_\_\_\_\_ **Any pending/recent surgeries** \_\_\_\_\_ **Any current/recent injuries**

Are your child's Immunizations Current? \_\_\_\_\_ Please explain any other medical concerns/Current

Medication(s): \_\_\_\_\_

## *Dental History*

Date of Last Dental Visit \_\_\_\_\_ By Dr. \_\_\_\_\_

Do you have any Current Records (including x-rays) from another practice? **Yes / No**

Has your child complained about any dental problems? \_\_\_\_\_

Any injuries or surgeries to mouth, teeth, or head? **Yes / No** If yes, please describe \_\_\_\_\_

Is your child breastfed? **Yes / No** Until what age? \_\_\_\_\_ Does your child still take the bottle or sippy cup? **Yes / No**

What does your child drink? \_\_\_\_\_

Does your child brush daily? **Yes / No** How Often? \_\_\_\_\_ Do you assist your child with Brushing? **Yes / No**

Is Dental Floss used? **Yes / No**

**Please indicate with a YES or NO.** Does your child have any of the following Mouth Habits?

\_\_\_\_\_ **Thumb Sucking** \_\_\_\_\_ **Mouth Breathing** \_\_\_\_\_ **Pacifier** \_\_\_\_\_ **Other** \_\_\_\_\_

\_\_\_\_\_ **Nail Biting** \_\_\_\_\_ **Finger Sucking** \_\_\_\_\_ **Grinding** \_\_\_\_\_

How does your child receive Fluoride?

- |                                       |                                     |                                  |                                      |
|---------------------------------------|-------------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Water Supply | <input type="checkbox"/> Toothpaste | <input type="checkbox"/> Tablets | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dentist      | <input type="checkbox"/> Vitamins   | <input type="checkbox"/> None    | _____                                |

How did you find out about our office? \_\_\_\_\_

Child's attitude towards dentistry: \_\_\_\_\_

Reason for Today's Visit/Chief Concerns: \_\_\_\_\_

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. I have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release of any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

----- OFFICE USE ONLY BELOW THIS LINE -----

Med. Hx. + / - Dr. Initials: \_\_\_\_\_ Name: \_\_\_\_\_