MORRO BAY FAMILY DENTISTY
INFORMATION/MEDICAL HISTORY

Child's
Name:_____
Last Name First Name Middle Initial

Male_____Age_____Birthday_____Nickname_____Hobbies_____
Female_____

Home address:_____
Street Apt# City State Zip Code

Mailing address:_____
Street Apt# City State Zip Code

Home Phone #_____Mom Cell #_____Dad Cell #_____

Email:_____

Whom may we thank for referring you?_____

INSURANCE/PARENT'S INFORMATION

Circle One:
Father Stepfather Guardian

Name_____

Address (if different from patient)_____

_____

Home Phone_____
(If different from above)

Employer_____

Social Security #_____

Birthday_____

Do you have dental insurance coverage for a minor/child?
YES NO

Insurance Co. _____

Phone # _____

Claims Address_____

_____

Group #_____

Policy/ID #_____

Circle One:
Mother Stepmother Guardian

Name_____

Address (if different from patient)_____

_____

Home Phone_____
(If different from above)

Employer_____

Social Security #_____

Birthday_____

Do you have dental insurance coverage for a minor/ Child?
YES NO

Insurance Co._____

Phone #_____

Claims Address_____

_____

Group # _____

Policy/ID #_____

DENTAL HISTORY

Child's Name_____

Date of last visit to a dentist____/_____/____, Last Cleaning/fluoride ____/_____/_____, Last X-Rays____/____/_____
Has child complained about dental problems? YES NO Is fluoride taken in any form? YES NO
Does child brush teeth daily? YES NO Any injuries to mouth, teeth, head? YES NO
Does child floss every day? YES NO Any unhappy dental experiences? YES NO

Any mouth habits? ____ thumb sucking_____nail biting____mouth breathing____pacifier_____sleeping with bottle_____

Other(please explain)_____

NAME AND PHONE NUMBER OF PREVIOUS DENTIST:_____

Child's Physician_____City/State_____Phone_____

Date of last physical examination_____Current Medical conditions_____

List of ALLERGIES (LATEX etc)_____

	YES	NO	
Does your child have Congenital Heart Disease?	_____	_____	Is antibiotic required?_____
Is child receiving any medication or drugs?	_____	_____	List Medications_____
Has child ever been hospitalized?	_____	_____	If so, why?_____
Has child ever had surgery?	_____	_____	List Surgeries_____
Is there excessive bleeding when cut?	_____	_____	Handicaps/Disabilities?_____

HAS CHILD EVER HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CIRCLE

Teeth grinding	Mouth breathing	Hearing impairment	Mononucleosis
ADD/ADHD	Cerebral Palsy	Heart Murmur	Mumps
Anemia (sickle cell or low iron)	Chicken Pox	Hepatitis	Rheumatic Fever
AIDS/HIV	Congenital Heart Defect	Hemophilia	Sinus Problems
Artificial Heart Valves	Diabetes	Kidney/Liver Disease	Thyroid Disease
Autism	Convulsions/Seizures	Learning Disability	Tuberculosis
Bladder Problems	Epilepsy	Measles	Cancer/Tumors
Fainting	Drug/Alcohol Abuse		

Psychological Problems (example:DD/communication skills-disorders)
Other (Please explain)_____
_____
_____

EMERGENGY CONTACT

In the event of an emergency, whom should we contact?_____
Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____

CONSENT FOR TREATMENT

The information that I have given is correct and completed to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the LEGAL GUARDIAN of the patient. I authorize Dr. Ratchford/authorized associates/staff to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine and any necessary x-rays on my child.

PROCEDURES WILL ALWAYS BE DISCLOSED TO YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian Signature_____Date_____

FINANCIAL AGREEMENT

* We accept assignment of MOST insurance plans. Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company.

* All charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We estimate your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.
* If the insurance company doesn't pay within a reasonable amount of time, it is required that you pay the balance due.
* Your insurance card must be presented at every visit. If there is no insurance card then payment (cash, check, or credit card) is expected at the time of service.
* I hereby authorize payment directly to MORRO BAY FAMILY DENTISTY, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.

PARENT/GUARDIAN
SIGNATURE_____DATE_____