LITTLE CHOMPERS
PEDIATRIC DENTISTRY

About Your Child

Child's Name: _____ Nickname: _____
Child's Date of Birth: _____/_____/_____ Male / Female
Residence Address: _____ City: _____ State: _____ Zip: _____
Residence Phone: _____ Email Address: _____
Please list any special interest, favorite toys, movies: _____
Who is Accompany the Child today?
Name: _____ Relation: _____
Whom may we thank for referring you? _____

Mother's Information
Name: _____
Date of Birth: _____/_____/_____
Home #: _____
Cell #: _____
Work #: _____

Father's information
Name: _____
Date of Birth: _____/_____/_____
Home #: _____
Cell #: _____
Work #: _____

Parents Marital Status: _____Single _____Married _____Widowed _____Divorced _____Separated.

Person Responsible for the Account

Name: _____ Relation: _____
Billing Address: _____ City: _____ State: _____ Zip: _____

DENTAL Insurance Information

Subscriber's Name: _____ Relation to Patient: _____
SSN #: _____ Date of Birth: _____/_____/_____ Employer: _____
Insurance Company: _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? _____ Yes _____No
If yes, complete the following.
Subscriber's Name: _____ Relation to Patient: _____
SSN #: _____ Date of Birth: _____/_____/_____ Employer: _____
Insurance Company: _____

Health History

What brings you in today? Pain / Check-up / Other
Please check any of the following treatments past or present in relation to patient.

____ ADD/ADHD
____ Abnormal Bleeding/Hemophilia
____ AIDS/HIV
____ Anemia
____ Artificial Bones/Joint
____ Asthma/Last Attack: _____
____ Autism Spectrum
____ Auto Immune Disorder
____ Cancer (type) _____
____ Cold Sore/Mouth ulcers
____ Congenital Heart Defect (Explain)
____ Diabetes (type) _____
____ Epilepsy
____ GI Issues (Explain)
____ Handicap/Disability
____ Hearing Impairment
____ Heart Murmur/Disorder (Explain)
____ Hepatitis
____ High/Low Blood pressure
____ Immune Suppressive Therapy/Illness
____ Kawasaki Disease
____ Kidney Issues
____ Liver Issues
____ Reflux/Gerd
____ Respiratory Issues
____ Sinus Issues
____ Snoring/Sleep Apnea
____ Tonsil/adenoid Removed

Please elaborate if necessary for checked conditions:

Are there any other conditions/treatments/surgeries not listed above or pending? YES/NO

Please describe:

MEDICATIONS

Current Medication:

Does your child require premedication for dental treatment (prosthetic heart valve or similar)? YES/NO

ALLERGIES

Please list your child's allergies: Include medications and/or foods.

Anaphylactic: YES/NO Other Reactions:

DENTAL HISTORY UPDATE

Last Dental Visit: _____

Has your child had any injuries to his/her head, face, mouth, or teeth? YES / NO

If yes Dates and specifics: _____

Are there any concerns with your child's teeth or his/her dental and/or oral health? YES / NO

If yes, please explain: _____

Please list any of your child's recent positive or negative medical/dental experiences that you feel are relevant:

OUR COMMITMENT TO EACH OTHER

Warranty: We guarantee all our work and will replace anything resulting from technique or material error at no cost to you if you maintain regular 6-month maintenances visits and complete all necessary work. Not doing these things will jeopardize the success of the work we perform. We offer this because we use the best material and techniques available.

Privacy Policy: We are committed to keeping all your information private and will not discuss or share personal information except with those authorized by you. Your email is kept private. We fully comply with all provisions with HIPAA.

Consent to Procedures: You authorize the doctors and/or staff at Little Chompers to perform those procedures agreed upon and within the standard of care for you (or at your request, too your minor child or ward). We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you to be completely comfortable through the entire process.

PAYMENT POLICY:

- You agree to be responsible for your own dental bill and to keep us updated of your current insurance information.
- We will bill your insurance as a courtesy; However, you are responsible for all services performed and charges received whether covered or not.
- All Co-payments are due at time of service.
- We accept cash, credit cards and checks. We offer 4- and 12-month payment plans, some at 0% interest OCA.
- We charge $30 for all missed appointments without 24-hour notice.
- You agree to pay $30 in late fees and interest charges assessed if your account becomes past due. If your account must be turned over to collections, you agree to pay up to a 40% collection fee of any unpaid balances.

I hereby certify that my answers to the forgoing questions are accurate. Since a change in my medical condition or medications can affect dental treatment, I agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature: _____ Date: _____

(Patient, legal guardian, or authorized agent of patient)