William B. Chan & Associates

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WELCOME!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to assist you. We look forward to working with you in maintaining your child's dental health.

Date____/____/_____ Name of Child (Last)_____-_____(First)_____(M.I.)_____

Child's Birthdate ____/____/____ Age_____ Sex ☐ M ☐ F

Legal Name _____Chosen Name _____ Sex at Birth ☐ M ☐ F Gender Identity_____

Nickname_____ Hobbies_____ Phone (____)_____-_____

Home Address (Street)_____(City)_____(State)_____(Zip)_____

Mailing Address (Street)_____(City)_____(State)_____(Zip)_____

School Name_____ School Phone # (____)_____-_____

Person Financially Responsible _____ Home (____)_____-_____Work (____)_____-_____

Whom may we thank for referring you? _____

Father/Guardian Name_____	Mother/Guardian Name_____
Address (if different)_____	Address(if different)_____
_____	_____
Home (____)_____ Work (____)_____	Home(____)_____ Work (____)_____
E-mail_____	E-mail _____
Employer_____	Employer_____
SSN:_____ D.O.B.___/___/___	SSN:_____ D.O.B.___/___/___
Do you have dental insurance for child? ☐ Yes ☐ No	Do you have dental insurance for child? ☐ Yes ☐ No
Plan Name _____ Ph: (____)_____	Plan Name _____ Ph: (____)_____
Address_____	Address_____
Group # _____ Policy #_____	Group # _____ Policy #_____

Date of last visit to a dentist_____ For what service? _____ Any unhappy dental experiences? ☐ Yes ☐ No

Has child complained about dental problems? ☐ Yes ☐ No Is fluoride taken in any form? ☐ Yes ☐ No

Does child brush teeth daily? ☐ Yes ☐ No Does child floss daily? ☐ Yes ☐ No Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any mouth habits (thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?) ☐ Yes ☐ No

(over)

Child's Physician_____ City/State_____ Phone (____)_____-_____

Date of last physical exam _____ Results_____

Is child under care of physician now? ☐ Yes ☐ No

Receiving any medication or drugs? ☐ Yes ☐ No Medications _____

Ever been hospitalized? ☐ Yes ☐ No _____

Ever had surgery? ☐ Yes ☐ No Allergies _____

Is there excessive bleeding when cut? ☐ Yes ☐ No _____

Has child had any history of or difficulty with any of the following? If yes, please check (✓)

( ) AIDS/HIV	( ) Cerebral Palsy	( ) Epilepsy	( ) Kidney Disease	( ) Rheumatic Fever
( ) Anemia	( ) Chicken Pox	( ) Fainting	( ) Liver Disease	( ) Sinus Problems
( ) Asthma	( ) Convulsions	( ) HearingProblems	( ) Measles	( ) Thyroid Disease
( ) Autism	( ) Diabetes	( ) Heart Problems	( ) Mononucleosis	( ) Tuberculosis
( ) Bladder Problems	( ) Drug/Alcohol Abuse	( ) Hepatitis	( ) Mumps	( ) Other
( ) Cancer				

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

Name _____ Relationship_____ Phone (____) _____-_____

Name _____ Relationship_____ Phone (____) _____-_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of (print name of child)_____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent is covered by insurance with (name of ins. Company)_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my child's healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of parent, guardian or personal representative Date

_____ _____

Printed name of parent, guardian or personal representative Relationship to Patient