Patient Medical History

Frisco Mini Molars

214-872-3434 • 5110 Eldorado Pkwy, Suite 600 • Frisco, TX 75034

FRISCO mini molars PEDIATRIC DENTISTRY LAURA MITCHELL, D.D.S.

Patient Information – We welcome your child into our practice and we will try to make his/her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Appointment Date _____

Patient Name _____ Nickname _____
LAST FIRST MI

✹ Male ✹ Female Siblings & Ages _____

Birth Date _____ E-mail _____ Age _____

Home Phone ( ) _____ School _____ Grade _____ Weight _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Health Information – Has your child ever had any of the following?

✹ AIDS	✹ Cerebral Palsy	✹ Immunizations up-to-date	✹ Pregnancy
✹ Allergies: Drugs or Latex	✹ Chicken Pox	✹ Kidney Problems	✹ Respiratory Problems
_____	✹ Diabetes I or II	✹ Liver Problems	✹ Rheumatic Fever
✹ Anemia	✹ Emotional Disorder	✹ Lung Problems	✹ Sinus Problems
✹ Asthma	✹ Epilepsy	✹ Medications	✹ Speech Problems
✹ Autism	✹ Hearing Problems	_____	✹ Surgeries
✹ Behavioral Problems	✹ Hepatitis	_____	✹ Thyroid Disorder
✹ Bleeding Disorder	✹ Heart Condition	✹ Mental Retardation	✹ Tuberculosis
✹ Blood Transfusion	✹ Hospitalization	✹ Mononucleosis	✹ Vision Problems
✹ Cancer	_____	✹ Mumps/Measles	✹ Other _____

Pediatrician Name _____ Last Visit _____ Phone _____

Has your child been seen by another dentist? ✹ No ✹ Yes, Name_____ Phone _____

Date of Last Visit _____ Cleaning ✹ Yes ✹ No X-rays ✹ Yes ✹ No Sealants ✹ Yes ✹ No Date of- Bitewings _____ Pano _____

Has your child had an unfavorable dental experience? _____ If yes, please specify: _____

Does your child have a past or <u>current</u> history of thumb/finger sucking? ✹ Yes ✹ No Pacifier? ✹ Yes ✹ No

Was your child breast fed? ✹ Yes ✹ No Bottle fed? ✹ Yes ✹ No Age discontinued: _____

What is your home water source? Public System ✹ Private Well ✹ Other _____

Consent for Services– As a condition of our treatment by this office, financial arrangements must be made in advance. The practice depends on the reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections for insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

The signature of a parent or guardian affixed below authorizes the completing of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date _____ Relationship to Patient _____
SIGNATURE OF PARENT OR GUARDIAN

Parent Information

Father's Name _____ ☐ Married ☐ Single
LAST FIRST MI

Email _____ Birth Date _____ Driver's License No. _____

Phone: Home ( )_____ Work ( )_____ Mobile ( ) _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Employer Name_____ Occupation _____

Employer's Address _____
STREET CITY STATE ZIP

Mother's Name _____ ☐ Married ☐ Single
LAST FIRST MI

Email _____ Birth Date _____ Driver's License No. _____

Phone: Home ( )_____ Work ( )_____ Mobile ( ) _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Employer Name_____ Occupation _____

Employer's Address _____
STREET CITY STATE ZIP

Emergency Information – Nearest relative not living in same household.

Name _____ Phone ( ) _____

Address _____

Primary Insurance Information

Name of Insured _____
LAST FIRST MI

Insured's Birth Date _____ Subscriber ID. _____ Group No. _____

Phone: Home ( )_____ Work ( )_____ Mobile ( ) _____

Address _____
STREET APT NO.

_____
CITY STATE ZIP

Employer Name_____ Occupation _____

Employer's Address _____
STREET CITY STATE ZIP

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address _____

_____ Insurance Company's Phone _____

I hereby authorize payment of dental benefits otherwise payable to me, directly to Frisco Mini Molars. Signature of Employee/Subscriber _____

Referral Information – Whom may we thank for referring you to our practice?

Office: ☐ *TYN*

☐ Another Patient (Friend) ☐ Another Patient (relative) ☐ Dental Office ☐ Internet ☐ School ☐ Work

Name of person or office referring you to our practice: _____