

**Thank you for visiting the office of Dawn Bova, DMD. We are pleased to welcome you and your child to our practice and look forward to helping you maintain your child's dental health. Please take a few minutes to fill out these forms as completely as you can. We will be happy to address your questions.**

### PATIENT INFORMATION

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Preferred Name (nickname, if any) \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Name of person accompanying child to 1<sup>st</sup> visit (MUST BE PARENT OR GUARDIAN) \_\_\_\_\_  
 Marital status of child's parents: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Never been married \_\_\_  
 With whom does the child reside? (name) \_\_\_\_\_ (relationship) \_\_\_\_\_  
 Primary contact person (for scheduling and billing) \_\_\_\_\_  
 Whom may we thank for referring you to us? \_\_\_\_\_

### FAMILY INFORMATION

<b>Mother's/Guardian's Information</b> Name _____ Date of Birth (required) _____ Social Security # (required) _____ Address _____ City _____ Zip code _____ Telephone numbers - Home: _____ Work: _____ Cell: _____ Email _____ Occupation _____ Employer _____	<b>Father's/Guardian's Information</b> Name _____ Date of Birth (required) _____ Social Security # (required) _____ Address _____ City _____ Zip code _____ Telephone numbers - Home: _____ Work: _____ Cell: _____ Email _____ Occupation _____ Employer _____
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In the event of an emergency, and if parents are unavailable, whom should we contact?  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### INSURANCE

<b>PRIMARY</b> Dental Insurance _____ Subscriber _____ Dental ID# _____ Group # _____ Dental Insurer Phone # _____	<b>SECONDARY</b> Dental Insurance _____ Subscriber _____ Dental ID# _____ Group # _____ Dental Insurer Phone # _____
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***PLEASE NOTE: You are responsible for your own dental coverage and benefits. Please ask if we are in your insurance network. Also, please note that the persona accompanying the patient is expected to make payment at the time of service (including estimates)***

### AUTHORIZATION

I certify that my child has dental insurance through \_\_\_\_\_ and assign directly to Dr. Dawn Bova 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 they are paid by my insurance carrier. I authorize the use of my signature on all health insurance submissions; I further authorize Dr. Bova to use my child's health and dental care information in the submission of all insurance claims in order to obtain payment for services and predeterminations.

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

## CHILD'S DENTAL HISTORY

You are responsible for the transfer of any previous dental records (including x-rays) for your child. If we do not have these records at the time of your child's visit, we may need to obtain new xrays.

Previous Dentist \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last dental exam \_\_\_\_\_ Results \_\_\_\_\_

Has your child had any injuries to his or her mouth, teeth, head, or any dental complaints (if so, please explain)?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child brush daily? \_\_\_\_\_ Floss daily? \_\_\_\_\_ Take fluoride (in any form) \_\_\_\_\_

Does your child have any oral habits such as thumb/finger sucking, use of a pacifier, sleeping with a bottle or sippy cup, mouth breathing, grinding, etc? If so, please specify: \_\_\_\_\_  
\_\_\_\_\_

Please specify any particular concerns, issuers, or questions that you would like to have us address:  
\_\_\_\_\_  
\_\_\_\_\_

## CHILD'S MEDICAL HISTORY

Child's Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_  
Date of last physical exam \_\_\_\_\_ Results \_\_\_\_\_

Is your child under the care of a physician at this time for anything other than routine exams? Is so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any kind of surgery? If yes, please explain why, where, and when: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child taking any medications? If yes, please list and explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies your child has, and the reactions he or she has experienced: \_\_\_\_\_  
\_\_\_\_\_

Does your child have a history of any of the following (circle all that apply )?

AIDS/HIV	Anemia	Asperger Syndrome	Asthma	Autism
Bladder Problems	Blindness	Cancer	Cerebral Palsy	Chicken Pox
Developmental delays	Diabetes	Down Syndrome	Drug/Acohol Abuse	Drug Allergies
Eating disorders	Emotional Issues	Epilepsy/Seizures	Fainting	
Head Injuries	Heart Murmur/Disease	Hepatitis	Kidney Disease	Latex Sensitivity
Liver Disease	Measles	Mononucleosis	Mumps	Rheumatic Fever
Sinus Problems	Speech Delay	Thyroid Disease	Tuberculosis	Other

## CONSENT

I certify that I am the parent or legal guardian of \_\_\_\_\_ and that there are no court orders now in effect (or expected) that prohibit me from giving legal consent for his or her care. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist of any changes regarding my child's health. I do hereby request and authorize Dr. Bova and her dental staff to perform necessary dental services for the child named above.

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_