



FAMILY & COSMETIC DENTISTRY

1305 Post Rd Ste 200 Fairfield, CT 06824 P: 203.255.5999 F: 203.255.9972

Welcome to our practice!

Child Name Birthdate Gender Female Male Neutral School Grade Address City State ZIP Preferred cell phone number Preferred Email How do you prefer to be contacted? Phone Call Text Email How did you hear about us? Friend/Family Google Yelp Instagram Facebook Other Who may we thank for referring your child to the office? Person to contact in case of emergency Phone # Person responsible for account Relation Family members seen by us List any sports or extracurricular activities

Parents' Marital Status: Single Married Divorced Widowed Significant Other

Please check one: Mother Step-Mother Guardian Other Name Birthdate SS # Driver License # Address (if different than child's) City State ZIP Home # Cell # Employer Occupation

Please check one: Father Step-Father Guardian Other Name Birthdate SS # Driver License # Address (if different than child's) City State ZIP Home # Cell # Employer Occupation

For Insurance purposes

Name of Subscriber ID # Insurance Co. Name Group #

Information Release Authorization & Payment of Benefits Authorization

I, _____, authorize the release of any information relating to any claim to third party payers. I hereby authorize and request my insurance company to pay directly to the dentist or dental office insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am aware that Mariana Conant, DDS, LLC makes every effort to conform to HIPAA Privacy Regulations but that my health care information may be released in the course of coordination of treatment, obtaining payment and health care operations.

Parent or Legal Guardian Signature: _____ Date: _____

CONTINUED ON BACK

Dental & Medical History (Minor)

Child Name _____ Age _____

Dental History

First dental visit? Yes No Previous X-rays taken? Yes No Date of last X-rays _____

Previous dentist's name _____ Date of last visit _____

Any unhappy dental experiences? Yes No

Do you have well water or city water? _____

Any oral habits like pencil biting, thumbsucking, nail biting, pacifier? _____

Medical History

Child's Physician and Phone # _____ Date of last exam _____

For any **YES** answer below, please explain:

1. Is your child under the **care** of a physician (other than routine care) now? Yes, _____ No
2. Does your child take any **medications** or supplements? Yes, _____ No
3. Does your child have any **allergies** (i.e.: Penicillin, latex, etc.)? Yes, _____ No
4. Has your child ever been **hospitalized**? Yes, _____ No
5. Has your child ever had **surgery**? Yes, _____ No
6. Is there anything **artificial** in your child's body, such as pins, shunts, rods, etc.? Yes, _____ No
7. Are there any **physical** problems? Yes, _____ No
8. Are there **learning** difficulties? Yes, _____ No
9. Were there problems at or before **birth**? Yes, _____ No
10. Does your child have **bleeding** disorders? Yes, _____ No

Check (x) if your child has or has had problems with any of the following:

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing | <input type="checkbox"/> Liver | |

Are there any current medical treatments including medications, pending surgery, recent injuries or any other medical condition not listed above? _____

Consent to Treatment

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. As the parent or guardian of the above minor patient, I do request and authorize the performance of dental services for this patient, and the performance of any procedures or techniques the dentist may deem necessary during treatment. I authorize the administration of anesthetics or analgesics which may be deemed advisable by the dentist. I authorize other individuals with whom I have placed the care of my child, such as other family members or caregivers, to sign consent for dental treatment for my child should they bring my child to any future appointments at Brickwalk Dental.

Parent or Legal Guardian Name: _____ Relation to patient: _____

Parent or Legal Guardian Signature: _____ Date: _____