Welcome to Rochester Family Dentistry

We are pleased to welcome you to Rochester Family Dentistry. Please take a few minutes to complete this form. If you have any questions, we'll be glad to help you. We look forward to working with you to maintain your dental health.

Patient Information

Date _____ Home Phone _____ Cell Phone _____

Name of Minor or Child _____
Last Name First Name Middle Initial

Sex ❑ M ❑ F Age _____ Birth date _____ Nickname _____ Hobbies _____

Home Address _____
Street City State ZIP

Mailing Address _____
Street City State ZIP

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

Dental Insurance

Father / Guardian's Name _____

Address (if different from patient's) _____

_____

Home phone _____ Work phone _____

Employer _____

Employer _____ Soc. Sec. # _____

Do you have dental coverage for minor / child? ❑ Yes ❑ No

Plan Name _____

Phone # _____

Address _____

Group # _____ Policy # _____

Mother / Guardian's Name _____

Address (if different from patient's) _____

_____

Home phone _____ Work phone _____

Employer _____

Employer _____ Soc. Sec. # _____

Do you have dental coverage for minor / child? ❑ Yes ❑ No

Plan Name _____

Plan Name _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ❑ Yes ❑ No Child's Medical Assistance # _____

Dental History

Date of last dental care _____ For what service? _____

	Yes	No		Yes	No
Has your child complained about dental problems?	❑	❑	Does your child take fluoride in any form?	❑	❑
Does your child brush daily?	❑	❑	Has your child had any injuries to the teeth, mouth, or head?	❑	❑
Does your child use floss every day?	❑	❑	Has your child had any unhappy dental experiences?	❑	❑
Does your child have any mouth habits – thumb sucking, nail biting, mouth breathing, sleeping with a bottle, etc?				❑	❑

Please Complete The Next Side Of This Form

Medical History

Minor/ Child's Physician _____ City / State _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No	
Is the minor / child under a physician's care now?	❑	❑	Medications: _____
Receiving any medications or drugs?	❑	❑	_____
Has the minor / child ever been hospitalized?	❑	❑	_____
Has the minor / child ever had surgery?	❑	❑	Allergies _____
Does the minor / child bleed excessively when cut?	❑	❑	_____

Has the minor / child had problems with any of these?

❑ A.I.D.S / H.I.V.	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney Disease	❑ Rheumatic Fever
❑ Anemia	❑ Chicken Pox	❑ Fainting	❑ Liver Disease	❑ Sinus Problems
❑ Asthma	❑ Convulsions	❑ Hearing Problems	❑ Measles	❑ Thyroid Disease
❑ Bladder Problems	❑ Diabetes	❑ Heart Problems	❑ Mononucleosis	❑ Tuberculosis
❑ Cancer	❑ Drug / Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization

The information that I have given is correct to the best of my knowledge. I understand that I will be held to the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor / child.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company (ies)

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.

_____ _____

Signature of Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

For Office Use

To be completed at a later visit:

Has there been any change in the patient's health since the last dental appointment? ❑ Yes ❑ No

If yes, please describe _____

Is the minor / child taking any new medications? ❑ Yes ❑ No If yes, please list: _____

Date _____ Parent / Guardian Signature _____

Date _____ Dentist Signature _____