

UPDATED BY PATIENT

1. ___/___/___ _____
 2. ___/___/___ _____
 Date Pt's initials

OFFICE USE ONLY

1. ___/___/___ _____ ___/___/___ _____
 2. ___/___/___ _____ ___/___/___ _____
 3. ___/___/___ _____ ___/___/___ _____
 Date Date Date Date

OFFICE USE ONLY

Date ___/___/___
 Acct. # _____

CHILD PATIENT INFORMATION

Child's Full Name _____ / ___/___
 Last First Middle Name Birth Date Age Sex
 Address _____
 Number & street Apt # City State Zip Code

RESPONSIBLE PARTY

Name, Address, and Phone Number of person responsible for this child's account

Last First Middle Name Number & Street City State Zip Code

Responsible Party's Relationship to Child _____ E-mail address _____

Responsible Party's Home Phone _____ Work Phone _____ Mobile Phone _____

Responsible Party's Social Security # _____ / _____ / _____

Responsible Party's Place and Address of Employment _____

Are Child's Parents: Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

PARENT INFORMATION (Please omit if same as above)

Father's Name _____ Phone _____

Address _____

(If same as above, please omit) Number & Street City State Zip Code

Mother's Name _____ Phone _____

Address _____

(If same as above, please omit) Number & Street City State Zip Code

PARENT EMPLOYMENT

Father's Place of Employment _____ Position _____

Length of Employment _____ Address _____ Phone _____

Mother's Place of Employment _____ Position _____

Length of Employment _____ Address _____ Phone _____

Child's Social Security # _____ / _____ / _____ Father's _____ / _____ / _____ Mother's _____ / _____ / _____

Have other members of your immediate family been patients here before? Yes No Relationship _____

Whom may we thank for referring you to our office? _____

Please list the name and phone number of a close friend or close relative **NOT RESIDING WITH YOU** who we may contact in case of an emergency or if we are unable to contact you.

Name _____ Relationship _____ Phone # _____

DENTAL INSURANCE

As a courtesy to you, we will file for primary dental insurance to your company. In order to do this, we must have one completed and signed form on file per patient **per calendar year**. If your insurance company has not remitted payment within 60 days of the date of service, the balance will be due and payable by the patient. Please complete the following information regarding dental insurance.

Primary Dental Insurance Company _____ Employer: _____ Employee: _____

Ins. Co. Mailing Address _____ Phone # _____

Employee S.S # ____/____/____ ID# _____ Group # _____ Employee's Birth date: ____/____/____



CHILD'S DENTAL AND MEDICAL HEALTH

Is your child ALLERGIC to Penicillin Codeine Local anesthetics Other medications (list) _____

Have you been told by a physician that your child needs an antibiotic premed before receiving any dental treatments? YES NO (please circle)

If yes, what medication is recommended by your doctor? _____ For what medical condition? _____

Please CIRCLE if your child has or has had any of the following:

- | | | | | |
|-------------------------|--------------------|---------------------|------------------------------|--------------------|
| Heart Murmur | Arthritis | Convulsions | Stroke | Fainting/Dizziness |
| Rheumatic Fever | Asthma | Jaundice | Ear/Eye/Nose/Throat Disorder | Thyroid Disease |
| Congenital Heart Lesion | Hepatitis | Sinus Trouble | Adrenal Disorders | Allergies |
| Heart Condition | Epilepsy | Kidney Trouble | Speech Problems | Hyperactivity |
| Blood Disease | Blood Transfusion | High Blood Pressure | Anemia | Diabetes |
| HIV Positive/Aids | Mental Retardation | | | |

Has your child every had any other serious illness not circled above? Yes No

Please describe in

detail: _____

1. Reason for child's visit today?

2. Child's Previous Dentist

_____ Name _____ Address _____ Phone _____

3. Child's Physician

_____ Name _____ Address _____ Phone _____

4. Does your child drink fluoridated water? Yes No

5. Is your child taking fluoride tablets / drops? Yes No

6. How often are your child's teeth brushed?

7. What type of toothpaste does your child use?

8. Does your child suck his thumb, finger, or lip? (circle which) Yes No

9. Has your child had problems with previous dental treatment? (Please describe) _____ Yes No

10. Does your child have a dental condition about which you are especially concerned? Yes No

(If yes, describe this condition)

11. Is this your child's first visit to the dentist? Yes No

12. Has your child been under a physician's care or hospitalized within the last two years? Yes No

Please state reason

13. Has your child taken any prescription medication during the past year? Please list _____ Yes No

14. Has your child had excessive bleeding requiring special treatment? Yes No

Please explain

15. Is your child subject to fainting spells? Yes No

16. Has your child had adverse effects from any dental anesthetic?

HIPPA (OPTIONAL)

I give my permission for the following person, _____ Relationship to
child _____,

to bring my child to dental appointments. This person also has my permission to update personal/medical history and to be involved in my
child's dental information and treatment.

Signature (Parent/Guardian) _____ Date _____

I verify that the preceding information is true. I authorize the release of information to my insurance company. I will allow Dr. Bentley and
his

Associates to discuss my conditions with my physician and to request medical information for him. I authorize the office of Mark T. Bentley,
D.D.S., Inc. or his agent to obtain and verify a credit report. I understand that there will be a fee for any broken appointment or any
appointment cancelled less than 24 hours, unless is an emergency.

CREDIT POLICY

A \$25.00 rebilling fee will be charged for each month your balance is overdue. A balance is overdue if not paid within 60 days from the
DATE OF SERVICE, regardless of insurance coverage. I understand that any legal fees incurred by this office in collection of the accounts
balance will be my responsibility.

Signature (Parent/Guardian)

If you are completing this form for the child but are not the parent/guardian, Please sign below and indicate your relationship to the child.

_____ Signature

(grandparent, aunt, sister, etc.)