Howell
Comprehensive General Dentistry
A Division of Atlantic Dental Care, PLC

Please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION [CHILD]

Name:	☐ Male ☐ Female	Date:	
Social Security #:	Birthdate:	Home Phone:	
Address:	City:	State:	Zip:
Email:		Cell Phone:	
If Student, name of School/College:	City/State:	☐ Full Time	☐ Part Time
Parent/Guardian's Employer:		Work Phone:	
Business Address:	City:	State:	Zip:
Parent/Guardian's Name:			
Name of Parent/Guardian with legal custody (if applicable):			
Who may we thank for referring you?		Phone Number:	
Emergency Contact:		Phone Number:	

INSURANCE INFORMATION

Name of Insured:			
Relationship to Patient:			
Social Security #:	Birthdate:	Date Employed:	
Name of Employer:	Union/Local #:	Work Phone:	
Employer Address:	City:	State:	Zip:
Insurance Company:	Group #:	Policy/ID #:	
Insurance Co. Address:	City:	State:	Zip:

Do you have additional dental insurance? ☐ Yes ☐ No If yes, please complete the following:			
Name of Insured:			
Relationship to Patient:			
Social Security #:	Birthdate:	Date Employed:	
Name of Employer:	Union/Local #:	Work Phone:	
Employer Address:	City:	State:	Zip:
Insurance Company:	Group #:	Policy/ID #:	
Insurance Co. Address:	City:	State:	Zip:

RESPONSIBLE PARTY

Name of Person Responsible for this Account:		
Relationship to Patient:		
Address:		Home Phone:
Email:		Cell Phone:
Driver's License #:		Birthdate:
Employer:	Work Phone:	Social Security #:
Is this person currently a patient in our office? ☐ Yes ☐ No		

Payment is required in full at each appointment.

For your convenience, we offer the following methods of payment. Please check the option you prefer:

☐ Cash ☐ Personal Check ☐ Discover ☐ VISA ☐ Master Card ☐ Care Credit

Parent/Guardian Signature: _____ Date: _____

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PATIENT MEDICAL/DENTAL HISTORY [CHILD]

Patient Name: _____ **Date:** _____

Physician: _____ **Phone Number:** _____

Previous Dentist: _____ **Date of last exam:** _____

	Yes	No
1. Has your child had difficulty with previous dental visits?	☐	☐
2. Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
3. Has your child been vaccinated for Human Papilloma Virus (HPV)?	☐	☐
4. Does your child:		
Suck thumb/finger	☐	☐
Suck/bite lips	☐	☐
Bite/chew nails	☐	☐
Chew hard objects (pencils, etc.)	☐	☐
Grind teeth	☐	☐
Clench jaws	☐	☐
5. Is your child's water fluoridated?	☐	☐
6. Does your child take fluoride supplements?	☐	☐
7. How often does your child brush?	☐	☐
8. How often does your child floss?	☐	☐

	Yes	No
9. Has your child ever had any of the following?		
Asthma	☐	☐
Cancer	☐	☐
Sleepy Apnea	☐	☐
Hepatitis	☐	☐
HIV/AIDS	☐	☐
Hemophilia	☐	☐
Diabetes	☐	☐
Allergies	☐	☐
Rheumatic Fever	☐	☐
Congenital Heart Defect	☐	☐
Handicaps/Disabilities	☐	☐
Convulsions/Epilepsy	☐	☐
Tuberculosis	☐	☐
Abnormal Bleeding	☐	☐
Heart Murmur	☐	☐
ADD/ADHD	☐	☐

Please list any other medical conditions your child has (including allergies):

_____

_____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____

Signature of Parent or Guardian Date

Doctor's Comments:

_____

_____

_____ _____

Signature of Doctor Date