**DR. ROCCO DeSantis, DDS** **501 E Kay St., Kilgore, TX 75662** **Phone 903-984-4231**

## 1 ABOUT YOUR CHILD

Today's Date File #:

Child's Name

Last First MI

Child's Nickname: ☐ Male ☐ Female

Child's Birthdate / / Age

School Grade

Child's Home Phone #: ( )

Child's SS#:

Child's Address

Apt/Condo #

City State Zip

Referred by:

If doctor, please give address & phone #.)

## 2 INSURANCE

PRIMARY DENTAL INSURANCE

**Co. Name:**

**Address**

City State Zip

Phone#( )

Insured's ID#:

Group # (Plan, Local, or Policy #):

Insured's Name: Relation:

Birthday / /

Insured's Employer:

Does either policy cover Orthodontics? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE

**Co. Name:**

**Address**

City State Zip

Phone#( )

Insured's ID#:

Group # (Plan, Local, or Policy #):

Insured's Name: Relation:

Birthday / /

Insured's Employer:

Does either policy cover Orthodontics? ☐ Yes ☐ No

## 3 CHILD'S FAMILY INFORMATION

Who is accompanying this dhild today?

FULL NAME IF OTHER THAN PARENT RELATION TO CHILD

Do you have Legal Custody of this Child? ☐ Yes ☐ No

How many Brothers/Sisters? Age(s)

Mother's Name:

☐ STEPMOTHER ☐ GUARDIAN

( ☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

Home Phone #: ( )

Work Phone #: ( ) EXT.

/ /

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH

MOTHER'S DRIVER'S LIC#.

Employer: How long?

EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name:

☐ STEP FATHER ☐ GUARDIAN

( ☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

Home Phone #: ( )

Work Phone #: ( ) EXT.

/ /

FATHER'S SOCIAL SECURITY # DATE OF BIRTH

FATHER'S DRIVER'S LIC#.

Employer: How long?

EMPLOYER'S ADDRESS CITY STATE ZIP

## 4 ACCOUNT INFORMATION

Person ultimately responsible for account

Name

RELATION TO CHILD

Billing Address:

Apt/Condo #

City State Zip

/ /

SOCIAL SECURITY # DATE OF BIRTH DRIVER'S LIC. #

( ) ( )

WORK PHONE # EXT. CELL PHONE #

Payment method: ☐ Cash ☐ Check ☐ CREDIT CARD

CARD # :

__________ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I Fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

## 5 Child's Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is child in pain? ☐ No ☐ Yes How long?

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw ☐ Lost/Broken Filling (s) ☐ Stained Teeth
☐ Red, swollen or bleeding gums ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth, or gums ☐ Ringing in ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth ☐ Broken/chipped tooth ☐ Loose tooth
☐ Other(s):

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't Know
Previous Dentist: ( )

Last Dental Exam: / / Last dental x-rays: / /

Times a day child brushes? Times a week child flosses?

Is the child's water fluoridated? ☐ Yes ☐ No

How would your rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

## 6 CHILD'S MEDICAL HISTORY

Is child taking any of the following medications? ☐ Pain Killers (incl. aspirin) ☐ Ritalin ☐ Stimulants ☐ Blood Thinners ☐ Tranquillizers ☐ Insulin ☐ Muscle relaxers ☐ Others:

Child Physician:

Phone # ( ) Last Medical Exam: / /

Address

CITY STATE ZIP

**Does your child have or ever had any of the following diseases or medical conditions or procedures?**

| | | |
|---|---|---|
| Y N Heart Murmur | Y N Tonsilitis | Y N High/Low Blood pressure |
| Y N Rheumatic / Scarlet Fever | Y N Respiratory Problems | Y N Hepatitis |
| Y N Artificial Hearth Valves | Y N Asthma/Difficulty Breathing | Y N Aritifical Bones/Joints/Implants |
| Y N Congenital heart defect | Y N Blood Transfusion(s) | Y N Liver/Kidney/Organ Problems |
| Y N Scarlet Fever | Y N Leukemia/Anemia | Y N HIV/AIDS/ARC |
| Y N Surgeries/Operations | Y N Diabetes/Hypoglycemia | Y N Tuberculosis (TB) |
| Y N Cancers/Tumors | Y N Hemophilia | Y N Psychiatric Problems |
| Y N Chemotheraphy | Y N Abnormal Bleeding | Y N Hyper Active/ADD |
| Y N Jaw Problems TMJ/TMD | Y N Cleft Lip/Palate | Y N Fainting/Serizures/Epilepsy |
| Y N Hearing Problems | Y N Birth Defects | Y N Cerebral Palsy |

Please list any other medical condition(s) child has or ever had:

**Is child allergic to:**

| | |
|---|---|
| Y N Aspirin | Y N Latex |
| Y N Dental Anesthetics | Y N Penicillin |
| Y N Amoxicillin | Y N Tetracycline |
| Y N Food Allergies | Y N Others |

Pleasre rate the child's general health from 1-10 Does your child wear contact lenses? ☐ Yes ☐ No

Has your child ever taken the drug Ritalin? ☐ No ☐ Yes/How long? Child's Blood Type:

Does your child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly/mutual understanding between provided and patient.
Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting agency fees, interest charges, and any other expenses incurred in collecting your account.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment. I also authorize the provided to release any information required to process insurance claims.
I understand that the information that I have given today is correct to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature Date: / /

☐ Parent/Guardian ☐ Other