CHERYL E. MCDONOUGH, DMD, APC
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PERSONAL INFORMATION

Child's Name ______________________ HOME Phone ( )______________________

ADDRESS ______________________

CITY, ST, ZIP ______________________

Patient Date of Birth ______________________

Patient Lives With: (please circle all that apply) Mother Father Step-Mother Step-Father Guardian

Person who is financially responsible:

Mother/Guardian ______________________ Father/Guardian ______________________

Mother DOB ______________________ Father DOB ______________________

Contact PH# ______________________ Contact PH# ______________________

Work Ph# ______________________ Work Ph# ______________________

Insurance:
Primary Carrier ______________________

Insured Person ______________________
ID# OR SS# ______________________

Employer ______________________

Group/Policy # ______________________
Insurance Co. Phone Number ______________________

Insurance:
Secondary Carrier ______________________

Insured Person ______________________
ID# OR SS# ______________________

Employer ______________________

Group/Policy # ______________________
Insurance Co. Phone Number ______________________

Who is responsible for this account? ______________________

Person to contact in case of emergency ______________________ *Phone no. (______)*______________________

HEALTH HISTORY
Age____________Height____________Weight____________Sex____________
Physician's Name and Phone Number______________________
Is child receiving any medication? __________ If so, what medication?
____

Does adolescent currently have, or previously had, any of the following?

Check appropriate box for yes or no						**Is child allergic to any of the following?**		
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Heart disease	□	□	Diabetes	□	□	Aspirin	□	□
Rheumatic fever	□	□	Frequent headaches	□	□	Codeine	□	□
Heart murmur	□	□	Tuberculosis	□	□	Novocain	□	□
Abnormal blood pressure	□	□	Asthma	□	□	Latex	□	□
Epilepsy or convulsions	□	□	Anemia	□	□	Any antibiotics	□	□
Tumor history	□	□	Excessive bleeding	□	□	If yes, what		
Cancer history	□	□	Hepatitis	□	□	antibiotic?		
Chemotherapy or radiation treatment	□	□	HIV+ or AIDS	□	□			
Current Immunizations	□	□	Thyroid disease	□	□			

If your child has, or has had, any disease, surgery, or condition not listed above, please describe below:

____

DENTAL HISTORY

Is this your child's first visit to the dentist? OR ______________________________

When did child last see a dentist? ______________________________

Dentist's Name ______________________________

Location ______________________________

Has your child made regular visits to the dentist in the past? ______________________________

Has your child ever had x-rays taken? ____________________

Has your child had any unfavorable reaction to previous dental treatment? ____________________

Does your child currently have sensitivity to hot, cold, or sweets? ______________________________

If so, where is it sensitive? ______________________________

Is your child having pain in the teeth or gums now? ____________________

If so, where is it painful? ____________________

How often does your child brush? ______________________________

Does your child have bleeding gums? ______________________________

What kind of toothbrush does your child use? ______________________________

Does your child need help brushing? ______________________________

Does child participate in athletic activities? ______________________________

Is your child able to floss? ____________________

Does your child use any type of oral rinse? ____________________

Does your child drink soda/juice/sports drinks? ____________________

If YES: How often? ____________________

Has your child had orthodontic treatment? ____________________

If YES: Who is/was their Orthodontist? ____________________

What is your long term goal for your child's oral health? ____

Do you have any specific questions or concerns? ____

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Date______________ Signature____Relationship________________

Terms and Conditions

This office depends on reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any insurance information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for the dental care can only be extended for a period of 90 days from the date of the patient's exam. I also understand that in order to collect my debt my credit history may be checked through the use of my social security number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered; the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions and agree to their content.

Date_______________Signature____Relationship________________