Snug DENTAL

Date (mm/dd/yyyy) _____

Personal Information

Patient's Name □ Male □ Female	*Preferred Name*	*Date of Birth*	*Age*
Street Address	*City*	*State*	*Zip*

Father's Name	*Social Security Number*	*Date of Birth*	
Street Address (□ Check if same as child)	*City*	*State*	*Zip*
Employer	*Email*		
Home Phone	*Business Phone*	*Cell Phone*	
Mother's Name	*Social Security Number*	*Date of Birth*	
Street Address (□ Check if same as child)	*City*	*State*	*Zip*
Employer	*Email*		
Home Phone	*Business Phone*	*Cell Phone*	

Insurance Information

Primary *Dental Insurance is Held by* □ Father □ Mother □ Other	*Dental Insurance Company*		
Insurance Company Address	*City*	*State*	*Zip*
* *Employer*	* *Employee*	* *Date of Birth*	
* *Policy Number / Social Security Number*	* *Group Number*		
Person Responsible for Account			
Whom may we thank for referring you to our office			

Secondary *Dental Insurance is Held by* □ Father □ Mother □ Other	*Dental Insurance Company*		
Insurance Company Address	*City*	*State*	*Zip*
* *Employer*	* *Employee*	* *Date of Birth*	
* *Policy Number / Social Security Number*	* *Group Number*		
Person Responsible for Account			

I, being the parent or guardian of the patient, do hereby authorize and request the performance of dental services for this patient. I certify that I have read and understand all information required on this form. I acknowledge that my questions, if any, have been answered to my satisfaction. By providing the contact information above, I am consenting to receiving electronic communications from Snug Dental Center about appointments and treatment. These communications may include voicemail, text, and/or email. You may request to opt out at any time but contacting our office.

_____ _____ _____

Signature of Parent / Guardian | Relationship | Date

Snug DENTAL

**** This information is that which we are required by the government to obtain from you to file insurance ****

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ……..… ☐ Yes ☐ No

☐ Active Tuberculosis ☐ Persistent cough greater than 3 week duration ☐ Cough that produces blood

If you answer YES to any of the three items above, please stop and return this form to the receptionist

Has the child had any history of, or conditions related to any of the following:

☐ ADD / ADHD	☐ Autism	☐ Growth Problems	☐ Jaundice	☐ SBE Pre-medication
☐ Allergy – Latex	☐ Bleeding Disorder	☐ Head Injuries	☐ Kidney	☐ Sickle Cell
☐ Allergy – Penicillin	☐ Cancer	☐ Heart	☐ Liver	☐ Sinus Problems
☐ Allergy – Sulfa	☐ Cerebral Palsy	☐ Heart Murmur	☐ Mental Disorder ☐	☐ Stomach problems
☐ Allergy - Other	☐ Cleft Lip / Palate	☐ Hepatitis	☐ Nervous Disorder	☐ Tuberculosis
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Pregnancy	☐ Tumors
☐ Artificial Joints	☐ Downs Syndrome	☐ HIV+ / AIDS	☐ Respiratory Problems	☐ Ulcers
☐ Asthma	☐ Epilepsy / Seizures	☐ Hydrocephaly	☐ Rheumatic Fever	☐ Other Condition

Please list the name and phone number of the child's physician:

Name of Physician _____ Office name: _____ Phone: _____

Child's History

	YES	NO
● Is the child taking any medications at this time? (if Yes, please list below) ……....	☐	☐
● Is the child allergic to any foods or medications? ……..	☐	☐
● Has the child ever had a serious illness or hospitalization? (if Yes, list details below)……..……..	☐	☐
● Has the child had any surgeries in the past? (if Yes, list details below)……..……..	☐	☐
● Does the child have any learning and / or speech problems? ... ……..…… .	☐	☐
● Has the child suffered any past injuries to the head, mouth, or teeth? ……..……..…….. .	☐	☐
● Is the child currently experiencing dental pain or discomfort? ……..……..……..	☐	☐
● Does the child suck a finger, thumb, or pacifier? ……..……..……..	☐	☐
● How many times per day does the child brush their teeth? _____ Who does the majority of the brushing? _____		
● Does the child use fluoride toothpaste? ……..……	☐	☐

● What was the date of the last dental visit? …… _____ / _____ / _____

● What services were performed at the last dental visit?

☐ Examination ☐ Fillings ☐ Cleaning & Fluoride ☐ Extractions ☐ Uncooperative for treatment

● What does the child mostly drink?

☐ City Water ☐ Well Water ☐ Filtered / Bottled Water ☐ Juice ☐ Milk ☐ Soda

● List details of prior hospitalizations or surgeries?

_____

_____

● List Medications:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of parent/legal guardian party: _____ Date: _____

Print name of parent/legal guardian: _____Date: _____