UDC University Dental Care LLC

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WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational**. Our practice is based on **preventative care**. We strive to teach good oral care that will enable your child to have **a beautiful smile that lasts a lifetime.**

Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to assist you. We look forward to working with you in maintaining your family's dental health.

About your child:

Name_____
Last First M.I.
Nickname _____
Birthdate_____/_____/_____ ☐Male ☐Female
SS#_____ Age_____

Special interests, sports, or hobbies: _____
_____
_____

Home Address_____
City_____ State____ ZIP_____
Home Phone _____

Referred by _____

About you:

Name_____
Last First M.I.
Birthdate_____/_____/_____ ☐Male ☐Female
SS#_____ Age_____
Relationship to Child_____
Home Address: ☐same as child
_____
Address
_____
City State ZIP
Home Phone _____
Occupation_____
Employer_____
Work Phone_____
Cell Phone_____

Primary Dental Insurance:

Insurance Company _____
Policy #_____ Group #_____

This Dental Insurance is provided through:

Policy owner's name _____
Relationship to child _____
Policy owner's SS# _____
Policy owner's DOB _____
Policy owner's employer_____

Additional Dental Insurance:

Insurance Company _____
Policy #_____ Group #_____

This Dental Insurance is provided through:

Policy owner's name _____
Relationship to child _____
Policy owner's SS# _____
Policy owner's DOB _____
Policy owner's employer_____

Emergency Contact:

Name _____
Relationship_____
Cell Phone _____
Other Phone _____

The Parent of Gaurdian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Method of Payment ☐Cash ☐Check ☐Credit Card

Signature_____ **Date**_____

DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? ☐Yes ☐No

If yes, the approximate date of last visit:_____

Are there any dental problems that you are aware of at present? ☐Yes ☐No

If yes, please explain: _____

Does your child brush his/her teeth daily? ☐Yes ☐No

Please rate your child's oral health: ☐Good ☐Fair ☐Poor

Is your child currently under the care of a physician? ☐Yes ☐No

Child's physician _____

Physician's phone number _____

The approximate date of last visit _____

Please rate your child's medical health: ☐Good ☐Fair ☐Poor

Is your child allergic to any drugs? ☐Yes ☐No

If yes, please list: _____

Is your child taking any prescription drugs? ☐Yes ☐No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? ☐Yes ☐No

Has your child ever had any of the following medical conditions or problems?

	Y	N
Any hospital stays	☐	☐
Any operations	☐	☐
Bleeding problems of any kind	☐	☐
Cancer, *type*_____	☐	☐
Convulsions/Epilepsy	☐	☐
Diabetes	☐	☐
Hearing impairment	☐	☐
Heart murmur	☐	☐
Heart problems of any kind	☐	☐
Hemophilia	☐	☐
AIDS/HIV+	☐	☐
Hyperactive	☐	☐
Rheumatic/Scarlet Fever	☐	☐

Are there any other medical conditions relating to your child? ☐Yes ☐No

If yes, please list:_____

_____

_____

Does your child suck his/her thumb or fingers? ☐Yes ☐No

Does your child suck or bite his/her lips? ☐Yes ☐No

Does your child bite his/her fingernails? ☐Yes ☐No

Does your child still use bottles? ☐Yes ☐No

ASSIGNMENT & RELEASE:

I hereby authorize payment directly to University Dental Care, LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor of UDC and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____ **Date**_____

AUTHORIZATION:

I understand the importance of a truthful health history to assist the doctor to provide the best care possible. I have had the opportunity to discuss my health history with my doctor.

I authorize and give consent to perform dental services agreed between University Dental Care, LLC and patient and/or legal guardian to be necessary or advisable including the use of anesthesia and other medications as indicated. I certify to the accuracy of the above statements regarding my dental and medical history. Payment for all treatment and services rendered are my responsibility.

Signature_____ **Date**_____

OFFICE USE ONLY:

Completetion Reviewed By _____