



Information (CHILD UNDER 18)

Name _____ Preferred Name _____ Sex _____

Home Address _____

Home Phone () _____

Age _____ Date of Birth _____

School _____ Grade _____

EMERGENCY CONTACT:

Name _____ Relation _____

Home Address _____ Home Phone () _____

WHO WOULD YOU LIKE THE APPOINTMENTS CONFIRMED WITH?				
MOTHER		FATHER		
How would you like us to confirm the appointments? (Please circle one of the following)				
Text Message	Email	Home Phone	Cell Phone	Work Phone

FATHER'S INFORMATION					
THE PERSON RESPONSIBLE FOR THE ACCOUT?		YES	NO		
LAST NAME			FIRST NAME		
ADDRESS			BIRTHDATE		
CITY	STATE		ZIP		
DRIVERS LISCENSE #	SOC. SEC. #				
EMPLOYER	OCCUPATION				
EMAIL ADDRESS					
HOME PHONE					
WORK PHONE					
CELL PHONE					
Marital Status:					
Single	Married	Separated	Divorced	Widowed	Remarried

MOTHER'S INFORMATION					
THE PERSON RESPONSIBLE FOR THE ACCOUT?		YES	NO		
LAST NAME			FIRST NAME		
ADDRESS			BIRTHDATE		
CITY		STATE		ZIP	
DRIVERS LISCENSE #		SOC. SEC. #			
EMPLOYER		OCCUPATION			
EMAIL ADDRESS					
HOME PHONE					
WORK PHONE					
CELL PHONE					
Marital Status:					
Single	Married	Separated	Divorced	Widowed	Remarried

Dental Insurance: Primary					
Insurance Co. Name		Phone		Group/Policy #	
Employer			Insured's Name		
Member ID#		Soc. Sec.#		Date of Birth	

Dental Insurance: Secondary					
Insurance Co. Name		Phone		Group/Policy #	
Employer			Insured's Name		
Member ID#		Soc. Sec.#		Date of Birth	

What is the name/phone number of the child's previous dental office?

Does the patient have any of the following habits?					
Clenching	Finger Sucking	Lip Biting	Nail Biting	Gum Chewing	Ice Chewing

MEDICAL HISTORY

YES	NO	
		Do any of the patient's teeth hurt? If yes, how long?
		Are any of the patient's teeth sensitive to sweets or cold? If yes, how long does the sensation last?
		Have there been any injuries to the patient's mouth or teeth? If yes, describe
		Has the patient ever had any injury to the head and neck area? If yes, describe
		Has the patient ever fallen and bumped their chin, or received a blow to the jaws? If yes, describe
		Has the patient ever had any surgery in the head and neck area? If yes, describe
		Has the patient ever had complications or illness following dental treatment? If yes, when
		Has the patient ever been told they have periodontal disease (gum disease)? If yes, describe
		Does it hurt to chew? If yes, where does it hurt?
		Does the patient hear clicking, popping, or grating sounds in the jaw joints? If yes, describe
		Has the patient ever been required to take antibiotics before visiting the dentist. If yes, why?
		Does the patient drink bottled water?

I have reviewed the above medical and dental information, and find it accurate. If there are any later changes in my clinical history, I understand that it is my responsibility to inform Dr. Flannagan. I also give permission for Dr. Flannagan to perform a clinical examination and to make recommendations for treatment. *******I have chosen the dental provider: Dr. Flannagan, First Impressions Family Dental Care of my own free will.**

X _____ (please initial)

I certify that I am covered by _____ insurance company and I assign directly to First Impressions Family Dental Care, PC all insurance benefits otherwise payable to me.

I understand I am responsible for payment of services rendered and also responsible for paying any fees, co-payment and deductible that my insurance does not cover. I also agree to pay interest at the rate of 18% APR on any balance over 90 days from the date of service. I further agree to pay any collection fees, attorney fees, and court cost should these means of collection become required. **I understand I am responsible for any collection agency fees and/or a fee for missed appointments if sufficient notice is not given. If we have not received sufficient notice, a charge may be applied to your account.** The undersigned allows First Impressions Family Dental Care, PC to use patient photos (withholding all names) as educational tools within our practice. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I acknowledge that I have received a copy of Dr. Flannagan's "Notice of Privacy Act" –HIPPA Act and Dr. Flannagan's Office Policy.

X _____

Date: _____