bondds DENTAL STUDIO

Child Information

Child's Name: _____ Nickname: _____
Last First MI

Date of Birth: _____ Age: _____ Gender: ○ Male ○ Female

Child resides with: ○ Mother ○ Father ○ Both Legal Guardian: _____
Relationship to Child

Parent's Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

Child's Home Address: _____
Street City State Zip Code

Phone Number: _____ Child's Interests: _____

Grade: _____ School Name: _____

Person Responsible for Child's Account: _____

E-mail: _____

Address of Person Responsible for Account: _____
If different than Child's Address

Parents Information

Father: _____ SSN: _____

Father's Birth Date: _____ Father's Cell Phone: _____

Mother: _____ SSN: _____

Mother's Birth Date: _____ Mother's Cell Phone: _____

Father's Employer: _____

Business Phone: _____ Occupation: _____

Mother's Employer: _____

Business Phone: _____ Occupation: _____

Insurance Information

Name of Dental Insurance Company, if any: _____

Name of Insured: _____ Insurance ID#: _____

Insurance Company Phone and Address: _____

Other Children in Family (Please list names and ages):

_____

Child's Physician: _____ Former Dentist: _____

Preferred confirmation methods: ○ E-mail ○ Phone ○ Text

Whom may we thank for referring you to our office? _____

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Child's Health History

Child's Name: _____ Nickname: _____

Last First MI

Has your child had any history of:

- ◯ Heart Trouble
- ◯ Allergies
- ◯ Diabetes
- ◯ Asthma
- ◯ Kidney or Liver Issues
- ◯ Seizures or Convulsions
- ◯ Bleeding Disorder
- ◯ Brain Injury
- ◯ Emotional, Nervous or Learning Disorder
- ◯ Other _____

Check One

	Yes	No
Has your child ever been in the hospital overnight, or had any type of operation?	◯	◯
If yes, please explain: _____		
Is there anything concerning your child's medical history which you feel may be important?	◯	◯
_____		
Does your child have allergies? (Medicine or Food)	◯	◯
If yes, please list: _____		
Does your drinking water contain fluoride?	◯	◯
Does your child have any of the following habits? ◯ Finger/Thumb Sucking ◯ Pacifier ◯ Mouth Breathing ◯ Teeth Grinding	◯	◯
Does your child snore? If yes, is it nightly? _____	◯	◯
Does your child brush daily? ◯ AM ◯ PM ◯ After Meals ◯ Supervised	◯	◯
Do you have concerns about your child's bite or the position of his/her teeth?	◯	◯
Is your child currently under medical care?	◯	◯
If yes, please explain: _____		
Is your child taking medication?	◯	◯
If yes, please list: _____		
Has your child experienced any unfavorable reaction from previous dental or medical care?	◯	◯
_____		

I hereby authorize and direct the Doctors of Bondds Dental Studio, assisted by dental auxiliaries of their choice, to perform upon my child (or legal ward for whom I am empowered to consent) dental services that in their judgment are advisable with the exception of:

_____

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to the tongue, lips or cheek, damage to and the possible loss of existing teeth and or fillings, injury to nerves near the treatment site and fracture to a tooth which may need additional treatment. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I understand that I am free to withdraw my consent to treatment at any time, and this consent will remain in effect until such time that I choose to terminate it. If there is ever a change in my child's health, I will inform the doctor at the next appointment.