PETER M. HECKLER, D.D.S., INC.
NANCY MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION

Date _____

Child's Name _____

Nickname _____

Date of Birth_____Age_____Sex _____

SS#_____Grade _____

School Attending _____

Hobbies_____

How did you hear about us?_____

PARENT INFORMATION

Father's Name _____

RESIDES WITH CHILD? _____YES _____NO

SS#_____Date of Birth _____

Address _____

City/State/Zip _____

Home Phone_____Work Phone _____

Cell Phone_____Email _____

Employer _____

Occupation_____

Employer's Address _____

City/State/Zip _____

Driver's License # _____

Mother's Name _____

RESIDES WITH CHILD? _____YES _____NO

SS#_____Date of Birth _____

Address _____

City/State/Zip _____

Home Phone_____Work Phone _____

Cell Phone_____Email _____

Employer _____

Occupation_____

Employer's Address _____

City/State/Zip _____

Driver's License # _____

GENERAL INFORMATION

Has your family been here before? _____Yes _____No

Name and Ages of Brothers and Sisters_____

_____

DENTAL INSURANCE INFORMATION

Name of Insured _____

Relationship to patient _____

Insured's birth date_____SS#_____

Employer_____Date Employed _____

Employer Address _____

Insurance Company _____

Group # _____

Ins. Co. Address _____

ADDITIONAL INSURANCE

Name of Insured _____

Relationship to patient _____

Insured's birth date_____SS#_____

Employer _____

Employer Address _____

Insurance Company _____

Group # _____

Ins. Co. Address _____

RESPONSIBLE PARTY

Who is responsible for the account?

Name _____

Birth date_____SS# _____

Relationship to patient _____

Address _____

City/State/Zip _____

Employer _____

Employer Address_____

Work Phone_____Home Phone _____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____Cash _____Personal Check _____Credit Card _____Visa _____MC

Late charges: If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child

during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

X_____

Signature of patient or parent if minor Date

HEALTH HISTORY

Child's Physician_____Phone _____

	Yes	No
Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time?	☐	■
If yes, please list _____		
Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs?	☐	■
If yes, please explain _____		
Is the child allergic to anything else such as certain drugs? If yes, please explain: _____	☐	■
How would you describe the child's eating habits? _____		
Has the child ever had a serious illness? If yes, when _____ please describe _____	☐	■
Has the child ever been hospitalized?	☐	■
Has the child ever received general anesthesia?	☐	■
Does the child have any speech difficulties?	☐	■
Has the child ever had a blood transfusion?	☐	■
Is the child physically, mentally, or emotionally impaired?	☐	■
Does the child experience excessive bleeding when cut?	☐	■
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: _____	☐	■
Has the child had any problem with dental treatment in the past?	☐	■
Has the child ever had dental radiographs (x-rays) exposed?	☐	■
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	■
Has the child had any problems with the eruption or shedding of teeth?	☐	■
Has the child had any orthodontic treatment?	☐	■
What type of water does your child drink? _____ City water _____ Well water _____ Bottled water _____ Filtered water		
Does the child take fluoride supplements?	☐	■
Is fluoride toothpaste used?	☐	■
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____		
Does the child suck his/her thumb, fingers or pacifier?	☐	■
Does child participate in active recreational activities?	☐	■

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

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder
- ☐ Bleeding Disorders
- ☐ Bone/Joints
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Sinusitis
- ☐ Diabetes
- ☐ Earaches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth Problems
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ HIV + / AIDS
- ☐ Immunizations
- ☐ Kidney
- ☐ Latex Allergy
- ☐ Liver
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (Teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Thyroid
- ☐ Tobacco / Drug Use
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Others please list _____

_____

_____

_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff on the next appointment without fail.

X_____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor_____Date_____BP _____

History Review and Significant Findings_____