Welcome to the office of

Child Information

www.NorthCantonSmiles.com

Child's Name:____ Nickname:________________
First Middle Last
Sex: M____ F_____ Birth date:_____________ Age:______ Reason for visit?____________________
Is this your child's first dental visit?__________Date of last dental visit?______________________
What is your child's attitude toward previous dental care?________________________________
Have we seen other children in your family?_______ Names_______________________________
Whom may we thank for referring you to our office?___________________________________
Is your child adopted?__________

Medical Information

Is your child under a physicians care now?______ For what reason?________________________
Physician's name____________________________________ Ph #:_______________________
Is your child on medication or drugs?___________
What kind?____________________________________ Reason?______________________________
Has your child ever been hospitalized?__________ When?__________ Reason?________________

Has your child had a history or difficulty with any of the following?

Premature Birth	• Yes	• No
Brain Injury	• Yes	• No
Heart	• Yes	• No
Cancer or Malignancies	• Yes	• No
Bone Disorder	• Yes	• No
Rheumatic Fever	• Yes	• No
Kidneys	• Yes	• No
Bleeding	• Yes	• No
Cerebral Palsy	• Yes	• No
Anemia	• Yes	• No
Speech Disorder	• Yes	• No
Diabetes	• Yes	• No
Hepatitis	• Yes	• No
Allergies to Medication	• Yes	• No
Seizures	• Yes	• No
AIDS	• Yes	• No
Asthma	• Yes	• No
Liver	• Yes	• No
Hearing	• Yes	• No
Gag Reflex	• Yes	• No
Earaches	• Yes	• No

Comments / details ____

Does your child have any emotional or school problems?_____________________________________

Dental Information

Was your child bottle fed?_______ Until what age?_______ Or breast fed?________ Until what age?________
Does your child have any mouth habits, finger/ thumb sucking _____ pacifier_______ other ____________
Has your child ever had any injuries to his teeth, mouth or head?______ When?______ Details?__________
Does your child brush regularly?_______ Does an adult assist with brushing?___________
Does your child floss?_________ Does an adult assist with flossing?__________
Has either parent or child been treated orthodontically?__________ Who?________________________
How would you expect your child to behave in our office?____________________________________
Describe your child: Outgoing____ Shy____ Stubborn____ Anxious____ Frightened____
How may we help to make this visit a positive experience for your child?___________________________

General Information

This information is requested for financial and credit purposes.

FATHER (full name)____

Address________________________________ City_____________________ State_______ Zip_______

Home Ph #__________________ SS#_____-_____-______ Birth date__________ Marital Status:_________

Employer____________________________ Work Ph #_________________ Cell Ph #________________

Address____________________________ City_______________ State_________ Zip______________

Email Address____ Driver License Number______________

MOTHER (full name)____

Address________________________________ City_____________________ State_______ Zip_______

Home Ph #__________________ SS#_____-_____-______ Birth date__________ Marital Status:_________

Employer____________________________ Work Ph #_________________ Cell Ph #________________

Address____________________________ City_______________ State_________ Zip______________

Email Address____ Driver License Number______________

Name of nearest relative_______________________ Home Ph #______________ Work Ph #_____________

Relation to which parent and relation to patient____

Insurance Information

Primary Dental Insurance

Name of subscriber_______________________________ Subscribers ID____________ Grp. No.__________

Name of Insurance Co. ____ Ph #___________________

Address____________________________________ City__________________ State_____ Zip ________

Policy holders employer____

Secondary Dental Insurance

Name of subscriber_______________________________ Subscribers ID____________ Grp. No.__________

Name of Insurance Co. ____ Ph #___________________

Address____________________________________ City__________________ State_____ Zip ________

Policy holders employer____

Assignment of Benefits: I authorize Dr. Bertolini to furnish my insurance company with all the information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Dr. Bertolini. I understand I am responsible for charges not covered by this assignment.

Our financial policy is to receive payment in full by the time treatment is completed. If this is not convenient for your, we do accept VISA, Discover , Mastercard and can direct you to other sources of credit. If you have dental insurance, we will submit your claim and you will be billed for any remaining balance not paid by your insurance company.

SIGNATURE: ____ ***DATE:***____________________

Patient, parent or guardian