



Pediatric Dentist
 David H. Moore, DDS, MS
 Cecilia Hwang, DDS
General Dentist
 Carrie Dunlap, DDS
Orthodontist
 S.J. Burrow III, DDS, MS, PLLC

For Office Use Only
Date Rec: _____
Acct #: _____

Patient Information

Child's Full Name _____ Name Called By _____
 Age _____ Birthday _____ / _____ / _____ Sex: M _____ F _____ Place of Birth _____
 Child's Home Address _____
 City _____ State _____ Zip Code _____ Hm Phone () _____

Child's Favorite Hobbies/Interests _____
 Name of School/Day Care _____
 Brothers (Names & Ages) _____
 Sisters (Names & Ages) _____

Child's Physician _____ Phone () _____
 Address _____ Date of Last Exam _____

What is your Child's Current Weight? _____ What is your Child's Current Height? _____

Parent/Guardian Information

Parent/Guardian Name _____ Relationship to Patient: _____
 S.S. # _____ - _____ - _____ Date of Birth: _____
 Employer: _____ Work/Mobile Phone () _____

Parent/Guardian Name _____ Relationship to Patient: _____
 S.S. # _____ - _____ - _____ Date of Birth: _____
 Employer: _____ Work/Mobile Phone () _____

Email Address _____

How did you find out about our office? _____

Emergency Contact-Friend or Relative Not Living with You

Name _____ Phone () _____
 Address _____ Zip Code _____

Insurance Information

Insured's Name _____ Relationship to Patient _____
 Insured's Date of Birth _____ Insured's Employer _____
 Name of Insurance Company _____ Group Number _____

I have received the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

 Signature of Insured Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to David H. Moore, DDS, MS, PA.

 Signature of Insured Date _____

MEDICAL HISTORY

Please indicate with a **YES** or **NO**. Does your child currently have/preciously had any of the following health problems?

_____ Allergies (Food, Dust, Drug, Unknown)

If yes, Please List _____

_____ Rheumatic Fever / Rheumatic Heart Disease

_____ Congenital Heart Disease or Heart Murmur

If yes, Premed Needed? _____

Name of Pharmacy: _____

Pharmacy Phone Number: _____

_____ Asthma or Hay Fever (Please Indicate)

If yes, please list any current medications: _____

_____ Arthritis or Rheumatism (painful, swollen joints)

_____ Convulsions, Seizures, Fainting, or Epilepsy

_____ Anemia or Blood Disorders

_____ Speech, Learning, or Hearing Disorders

_____ High/Low Blood Pressure

_____ Any Current/Recent Injuries

_____ Childhood Illnesses

_____ Blood Transfusion

_____ Any Prolonged Bleeding/Bruises Easily

_____ Kidney or Bladder Problems

_____ Tuberculosis or Pneumonia

_____ Glandular or Hormonal Problems

_____ Diabetes/Blood Sugar Problems

_____ Liver Problems, Jaundice or Hepatitis

_____ Accidents or Severe Infections

_____ Psychological or Emotional Problems

_____ Any Pending/Recent Surgery

Are your child's Immunizations Current? _____

Please explain any other medical concerns/Current Medication(s): _____

DENTAL HISTORY

Date of Last Dental Visit _____ By Dr. _____

Do you have any Current Records (including x-rays) from another practice? **Yes** **No**

Has your child complained about any dental problems? _____

Any injuries or surgeries to mouth, teeth, head? **Yes** **No** If yes, please describe _____

Does your child still take the bottle or sippy cup? _____

Does your child brush daily? **Yes** **No** How Often? _____

Do you assist your child w/Brushing? **Yes** **No** How Often? _____

Is Dental Floss used? **Yes** **No**

Please indicate with a **YES** or **NO**. Does your child have any of the following Mouth Habits

_____ Thumb Sucking _____ Mouth Breathing _____ Pacifier _____ Other _____

_____ Nail Biting _____ Finger Sucking _____ Grinding _____

How does your child receive Fluoride?

- Water Supply Toothpaste Tablets Other _____
 Dentist Vitamins None _____

Child's Attitude Towards Dentistry: _____

Reason for Today's Visit/Chief Concerns: _____

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance. All balances over 30 days are subject to a 1.5% per month **finance charge**.

Signed _____ Date _____

Relationship to Patient _____