50 McAndrews Road East Burnsville, MN 55337
952-892-5050

WELCOME

We are committed to pursuing excellence through continuing education, personal and team growth and mastery of leading edge technology. It is our goal to hold firmly to lasting relationships we have established with our patients, while looking forward to relationships yet to be built.

PATIENT INFORMATION- Child

Patient Name ______________________________ Preferred Name ______________

SSN ______________________________ Sex M F DOB__________ Age _____

Address ______________________________

City ____________________ State _____ Zip _________

Patient's School ______________________________ Student Status PT FT

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

PARENT INFORMATION

Parent Name ______________________________ Relationship to Patient ______________

Address ______________________________ SSN __________ Marital Status: S M D W

City____________________ State ______ Zip _______ Sex M F DOB ___________

Home (______)________________ Cell (_____) ________________ Work (_____)________________

Parent's Employer/ School ______________________________ Student Status PT FT

Email ______________________________

- How would you like to receive your confirmations/ reminders? Email Text Phone

Parent Name ______________________________ Relationship to Patient ______________

Address ______________________________ SSN __________ Marital Status: S M D W

City____________________ State ______ Zip _______ Sex M F DOB ___________

Home (______)________________ Cell (_____) ________________ Work (_____)________________

Parent's Employer/ School ______________________________ Student Status PT FT

Email ______________________________

- How would you like to receive your confirmations/ reminders? Email Text Phone

INSURANCE INFORMATION

Will you be using dental insurance for your visit today? Yes No

If yes, please indicate the insurance information below.

PRIMARY INSURANCE

Subscriber ______________________ Relationship to patient ________________ DOB ____________

Insurance company name ____

Employer __________________________ ID# ____________________ Group# ____________

SECONDARY INSURANCE

Subscriber ______________________ Relationship to patient ________________ DOB ____________

Insurance company name ____

Employer __________________________ ID# ____________________ Group# ____________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ________________ and assign directly to Crestridge Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dental office may use my health care information and may disclose such information to the above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Court fees and 1.5% monthly interest charges will be applied to any delinquent accounts.

____

(Signature of Patient, Parent, Guardian or Personal Representative)

Medical and Dental History for Children 12 and Under

Patient Name ______________________________ D.O.B. ______________

Parent/ Guardian's Name ______________________ Relationship to Child ______________

Emergency Contact (Name/ Phone Number) ______________________________

Medical History

1. Does your child have any current health problems? .... Yes ○ No ○
   If yes, please explain ______________________________
2. Is your child under care of a physician? .... Yes ○ No ○
   Name of physician ______________________________
3. Is your child receiving any medications? .... Yes ○ No ○
   If so, what and when? ______________________________
4. Has your child had any serious illness? .... Yes ○ No ○
   If so, what and when? ______________________________
5. Has your child ever had surgery or is surgery contemplated? .... Yes ○ No ○
   Explain ______________________________
6. Does your child have a heart murmur or any other heart condition? .... Yes ○ No ○
7. Does your child experience severe or prolonged bleeding? .... Yes ○ No ○
   Explain ______________________________
8. Does your child have AIDS or has he/she tested HIV positive? .... Yes ○ No ○
9. Has your child tested positive for hepatitis? .... Yes ○ No ○
10. Has your child had a history of nervous disorders? .... Yes ○ No ○
11. Does your child have frequent headaches? .... Yes ○ No ○
12. Is your child allergic/sensitive to: ○None ○Codeine ○ Penicillin ○ Local ○Anesthetic ○Latex ○Pine ○ Nuts ○ Dyes
    Other: ______________________________
13. Has your child has history of:

Diabetes	Yes ○ No ○	Cerebral palsy	Yes ○ No ○
Asthma	Yes ○ No ○	Cancer	Yes ○ No ○
Hay fever	Yes ○ No ○	Leukemia	Yes ○ No ○
Kidney infection	Yes ○ No ○	Oral Heretic Lesion	Yes ○ No ○
Liver Problems	Yes ○ No ○	Eating disorders	Yes ○ No ○
Hepatitis/ Jaundice	Yes ○ No ○	Speech impairments	Yes ○ No ○
Thyroid Problems	Yes ○ No ○	Hearing impaired	Yes ○ No ○
Rheumatic Fever	Yes ○ No ○	Take pre-medication for anything	Yes ○ No ○
Epilepsy/ seizures/ Fainting	Yes ○ No ○	If yes, for what ______________	

Height: __________ Weight: __________

OVER