MARS
DENTAL SPECIALISTS, LLC

PATIENT AND FAMILY INFORMATION

CHILD'S NAME ______________________________

BIRTHDATE ______________ ☐MALE ☐FEMALE SOCIAL SECURITY # ______________

HOME PHONE ______________________________

HOME ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

SCHOOL ______________ GRADE ______________

RESPONSIBLE PARTY ______________ RELATIONSHIP TO CHILD ______________

NAME OF MOTHER/GUARDIAN ______________ BIRTHDATE ______________

SOCIAL SECURITY # ______________ HOME PHONE ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

EMPLOYER ______________ BUSINESS PHONE ______________ CELL PHONE ______________ E-MAIL ______________

NAME OF FATHER/GUARDIAN ______________ BIRTHDATE ______________

SOCIAL SECURITY # ______________ HOME PHONE ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

EMPLOYER ______________ BUSINESS PHONE ______________ CELL PHONE ______________ E-MAIL ______________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

CHILD'S DENTAL HISTORY

IS YOUR CHILD CURRENTLY IN PAIN? ☐YES ☐NO WHAT IS THE PRIMARY REASON FOR TODAY'S VISIT? ______________

FORMER DENTIST ______________ OFFICE PHONE ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

DATE OF LAST DENTAL VISIT ________ HAS YOUR CHILD EXPERIENCED PROBLEMS WITH PREVIOUS DENTAL WORK? ☐YES ☐NO

HOW OFTEN DOES YOUR CHILD BRUSH? ________ HOW OFTEN DOES YOUR CHILD FLOSS? ________

IS YOUR CHILD'S WATER FLUORIDATED ☐YES ☐NO IS YOUR CHILD TAKING FLOURIDE SUPPLEMENTS? ☐YES ☐NO

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD: ☐THUMB/FINGER SUCKING ☐LIP OR CHEEK BITING ☐FINGERNAIL BITING ☐JAW DIFFICULTY: CLICKING AND/OR PAIN ☐GRINDING ☐PACIFIER ☐SPEECH PROBLEMS ☐BREAST FED ☐NURSING BOTTLE

CHILD'S HEALTH HISTORY

PLEASE DESCRIBE YOUR CHILD'S CURRENT PHYSICAL HEALTH ☐GOOD ☐FAIR ☐POOR

ARE IMMUNIZATIONS CURRENT? ☐YES ☐NO

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ALLERGIES	☐ CANCER	☐ HIV/AIDS	☐ RHEUMATIC FEVER	☐ TUBERCULOSIS
☐ ANEMIA	☐ DIABETES	☐ HEART MURMUR	☐ SCARLET FEVER	☐ OTHER ______________
☐ ASTHMA	☐ EPILEPSY	☐ HEPATITIS-TYPE	☐ TONSILLITIS	______________

PLEASE LIST ALL MEDICATIONS YOUR CHILD IS CURRENTLY TAKING ______________________________

____

PLEASE LIST ALL DRUGS AND/OR OTHER THINGS THAT CAUSE YOUR CHILD ALLERGIC REACTIONS ______________

____

PRIMARY DENTAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

RELATIONSHIP TO PATIENT ______________________ BIRTHDATE ______________________

SOCIAL SECURITY # ______________________ HOME PHONE ______________________

ADDRESS ______________________ CITY __________ STATE ______ ZIP ________

EMPLOYER ______________________ BUSINESS PHONE ______________________

BUSINESS ADDRESS ______________________ OCCUPATION ______________________

INSURANCE COMPANY ______________________________

INSURANCE COMPANY ADDRESS ______________________________

SUBSCRIBER I.D. # ______________________ GROUP # ______________________

ADDITIONAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

RELATIONSHIP TO PATIENT ______________________ BIRTHDATE ______________________

SOCIAL SECURITY # ______________________ HOME PHONE ______________________

ADDRESS ______________________ CITY __________ STATE ______ ZIP ________

EMPLOYER ______________________ BUSINESS PHONE ______________________

BUSINESS ADDRESS ______________________ OCCUPATION ______________________

INSURANCE COMPANY ______________________________

INSURANCE COMPANY ADDRESS ______________________________

SUBSCRIBER I.D. # ______________________ GROUP # ______________________

ASSIGNMENT AND RELEASE

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZED THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED. MY METHOD OF PAYMENT WILL BE ______________________

____

SIGNATURE OF PARENT OR GUARDIAN DATE

I AUTHORIZE THE ABOVE DOCTOR AND/OR ANY PROVIDER OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE THE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

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SIGNATURE OF RESPONSIBLE PARTY DATE

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