Christopher M. Davis, D.D.S., P.A.
1422 Main Street, Suite 226. Southlake, Texas 76092
Phone 817-481-7733 Fax 817-481-6694

Date:_____

We sincerely welcome you and your child into our practice. We will make your dental visits as pleasant as we can. In order to better understand your child, please complete this form as thoroughly as possible. Thank You!

Child's Name _____ Nickname _____ Sex M ☐ F ☐

Age _____ Date of Birth _____ Weight _____ School _____

Name of Sibling (circle those we have seen) _____

Physician _____ Phone # _____ Date of last medical examination _____

Names of Child's Favorites (pet, toy, friend, etc.) _____

Whom may we thank for referring you to our office? (if referred by a patient, please indicate) _____

What is your main concern for this visit? _____

MEDICAL HISTORY

Is your child in good general health? Yes ☐ No ☐

Has your child had or does he/she have now...	YES	NO
Birth Defects	☐	☐
Cleft lip or palate	☐	☐
Food or pollen allergies	☐	☐
Allergic reaction to medication	☐	☐
If so, what? _____		
Is your child taking any medication now	☐	☐
If so, what? _____		
Difficulty with speech	☐	☐
Eye or sight disorder	☐	☐
Hearing loss or disorder	☐	☐
Kidney disease	☐	☐
Asthma, Cystic Fibrosis or respiratory disease	☐	☐
Any hospitalizations or surgeries	☐	☐
If so, what and when? _____		

	YES	NO
Heart disease or heart murmur	☐	☐
If so, is SBE prophylaxis needed?	☐	☐
Rheumatic fever	☐	☐
Tuberculosis	☐	☐
Emotional, mental or developmental disorder	☐	☐
ADD / ADHD	☐	☐
Diabetes, thyroid, or endocrine disease	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Epilepsy or any seizure disorder	☐	☐
Cerebral palsy or neurologic disease	☐	☐
Prolonged bleeding, hemophilia or anemia	☐	☐
Cancer, tumors or malignancies	☐	☐
Has your child ever tested HIV positive	☐	☐
Mouth injuries	☐	☐
Any other medical conditions?	☐	☐
If so, what? _____		

DENTAL HISTORY

Is this your child's first visit to our office? Yes ☐ No ☐ Has your child been seen in any other dental office? Yes ☐ No ☐

If so, where? _____

Date of last dental exam _____ Last x-rays _____

Does your child have any mouth habits such as finger sucking? Yes ☐ No ☐ If so, what? _____

Has your child experienced any unfavorable reaction from any previous medical or dental care? (state which) _____

_____

FAMILY HISTORY

Father's Complete Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Phone _____ Cell Phone _____ SS# _____ DL# _____

Mother's Complete Name _____ Date of Birth _____

Home Address (complete if different) _____ City _____ Zip _____

Phone _____ Cell Phone _____ SS# _____ DL # _____

Are parents divorced, separated, remarried or deceased? Yes ☐ No ☐ (If yes, please explain. Where does the child reside?) _____

_____

Father's Place of Employment _____ Address _____

City _____ State _____ Zip _____ Phone _____

Mother's Place of Employment _____ Address _____

City _____ State _____ Zip _____ Phone _____

Person to contact in case of emergency (not living at home); i.e., a relative or friend: Name _____

Address _____ City _____ State _____ Zip _____ Phone _____

PATIENT NAME _____

DENTAL INSURANCE

Dental Insurance Company _____ Group No. _____

Address _____ Phone No. _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. As a courtesy to our patients, we will file your dental insurance for you. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. It is also your responsibility to know your plan benefits. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Dr. Davis.

Signature _____

CONSENT FOR TREATMENT OF A MINOR

The undersigned is the person who has completed this form and is able to answer the above questions accurately. In addition, the undersigned has the legal authority to obtain dental care for the above named child. Furthermore, the undersigned hereby authorizes Dr. Davis and/or his associates to perform the examination and after explanation, the necessary dental services, including radiographs, and those methods he deems appropriate for the care of the above-named child. This consent shall remain in full force until cancelled by either party.

Signature _____ Relationship to child _____

ASSIGNMENT OF RESPONSIBILITY

We understand that at times it is not possible for the parent or legal guardian of a child to bring him/her in for a scheduled appointment or for emergency treatment. You may give permission for others to bring your child by filling out the following. If you leave this section blank ONLY a parent or legal guardian will be allowed to consent to treatment or schedule an appointment. I, as parent or legal guardian, give my permission for:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

to obtain dental treatment. Further, I will make sure the above individual(s) are aware of the medical history of my child and can answer all questions required for safe dental treatment. In addition, I understand that treatment plan changes may occur for a variety of reasons. I understand and agree that any treatment plan that may have been explained to me is subject to change and in some cases will change the fees quoted to me. Lastly, I will make arrangements for the above individual(s) to bring any necessary insurance forms and/or payment for services rendered at each visit.

Parent/Legal Guardian
Signature _____ Date _____

FINANCIAL POLICY

Payment is due at the time services are rendered, unless arrangements have been made prior to the scheduled appointment. Our office is not set up for billing. I understand that if I have to be billed for any reason I have 30 days to make payment in full or make payment arrangements with the accounts receivable department. Should I have to be billed more than once I understand that there is a $5.00 charge for each statement thereafter. Returned check charges are $35.00 per check.

Parent/Legal Guardian
Signature _____ Date _____