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 by you insurance. It is also your responsibility to know your plan benefits. I hereby authorize payment to 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 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 _____

PATIENT RESPONSIBILITY

It is your responsibility to become familiar with your insurance benefits and confirm our participation with your plan. Please contact your insurance company with any questions you may have regarding your coverage. If the services you receive are not covered by your insurance you will be responsible for all of the charges for the visit. **Your signature indicates that you understand that it is your responsibility to be aware of what services are covered and that, further, you agree to pay for any service(s) deemed to be non-covered or not authorized by the plan**.

Parent/Legal Guardian Signature _____ Date_____

FINANCIAL POLICY

Payment is due at the time of services 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 $5.00 charge for each statement thereafter. Returned check charges are $35.00 per check.

CHILDREN OF DIVORCED PARENTS:

Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of Davis Pediatric Dentistry.

Parent/Legal Guardian Signature _____ Date _____