Welcome!

PATIENT AND FAMILY INFORMATION

Patient Name _____ Birthdate _____
Home Address _____
City _____ State _____ Zip _____
Parent or Guardian's Name _____
Home Phone _____ Cell Phone _____

MEDICAL & DENTAL HISTORY

DENTAL HISTORY

Is this your child's first visit? YES NO
If no, what was the date of the last dental visit? _____
Are you aware of any particular dental problems? YES NO
If yes, please explain _____

MEDICAL HISTORY

Please check all that apply to your child:
__ Allergies: __ Aspirin __ Codeine __ Latex __ Local Anesthetic __ Penicillin
__ Other Allergies: _____
__ Anemia __ Diabetes __ Heart Murmur
__ Asthma __ Epilepsy __ Heart Trouble (Please Explain): _____
__ Cancer __ Radiation or Chemotherapy
__ Other: _____

PRIMARY DENTAL INSURANCE

Name of Policyholder _____
Relationship to Patient _____ Birthdate _____
Subscriber ID or Social Security Number _____
Insurance Company _____ Phone Number _____
Employer _____ Group Number _____

SECONDARY INSURANCE

Name of Policyholder _____
Relationship to Patient _____ Birthdate _____
Subscriber ID or Social Security Number _____
Insurance Company _____ Phone Number _____
Employer _____ Group Number _____

ASSIGNMENT, RELEASE, AND PRIVACY PRACTICE ACKNOWLEDGEMENT

I hereby authorize payment directly to Dr. Bradford G. Rice, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependants.

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.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient or Guardian _____ Date _____