Welcome To Mountain Bay Dental

Patient Information

First Name:_____ M.I.:___ Last Name:_____ Nickname:_____

M☐ F☐ DOB:_____ SS#:_____ School:_____ Grade:_____

Does the patient have any immediate family members that come here? Y N If yes, please name:_____

Home Address:_____ City:_____ State:____ Zip:_____

*Whom may we thank for referring you to us?*_____

Primary Parent/Guardian Information

Mother☐ Father☐ Guardian☐ Last Name:_____ M.I.:____ First Name:_____

DOB:_____ SS#_____ Employer:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____ Ext.:_____

Preferred Contact Phone: Home☐ Cell☐ Work☐ Email:_____

Secondary Parent/Guardian Information

Mother☐ Father☐ Guardian☐ Last Name:_____ M.I.:____ First Name:_____

DOB:_____ SS#_____ Employer:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____ Ext.:_____

Preferred Contact Phone: Home☐ Cell☐ Work☐ Email:_____

Primary Dental Insurance

If no insurance, complete this section for the person responsible for this account.

Insureds' Last Name:_____ M.I._____ First Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Other: _____

Preferred Contact Phone: Home☐ Cell☐ Other☐ Email:_____

DOB:_____ SS#_____ Drivers Lic.:_____Relationship to Patient:_____

Employer:_____ Dental Ins. Co.:_____ Subscriber ID:_____ Group #:_____

Secondary Dental Insurance

Insureds' Last Name:_____ M.I._____ First Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Other: _____

Preferred Contact Phone: Home☐ Cell☐ Other☐ Email:_____

DOB:_____ SS#_____ Drivers Lic.:_____Relationship to Patient:_____

Employer:_____ Dental Ins. Co.:_____ Subscriber ID:_____ Group #:_____

Payment/Authorization

I understand that payment is due in full at each visit unless otherwise agreed upon in writing. I hereby authorize payment directly to Mountain Bay Dental of the group insurance otherwise payable to me. I understand I am responsible for all costs of dental treatment. I hereby authorize Paxton Family Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Patient/Responsible Party Signature:_____ **Date:**_____

Your Child's Medical History

Please check the following for allergies:

Latex ☐ Penicillin/Amoxicillin ☐ Erythromycin ☐ Tetracycline ☐ Aspirin ☐ Codeine ☐ Iodine ☐

Sulfa ☐ Percodan ☐ Valium ☐ Acrylic ☐ Metals ☐ Dental Anesthetic ☐ Other:_____

Please check any of the following symptoms or conditions that you have or have had in the past.

☐ AIDS/HIV Infection ☐ ADHD ☐ Allergies ☐ Artificial Heart Valves (Date Placed:_____)

☐ Artificial Joints (Date Placed:_____) ☐ Asthma ☐ Autism ☐ Birth Defects ☐ Cancer

☐ Cerebral Palsy ☐ Chemotherapy ☐ Cleft Lip/Palate ☐ Congenital Heart Defect ☐ Diabetes

☐ Difficulty Breathing ☐ Dizziness/Fainting ☐ Downs Syndrome ☐ Epilepsy ☐ Hearing Problems

☐ Heart Murmur ☐ Hemophilia ☐ Hepatitis A, B or C ☐ High Blood Pressure ☐ Hypoglycemia

☐ Kidney Disease ☐ Leukemia/Anemia ☐ Liver Disease ☐ Low Blood Pressure ☐ Nervousness

☐ Psychiatric Care ☐ Radiation ☐ Respiratory Problems ☐ Rheumatic Fever ☐ Scarlet Fever

☐ Seizures ☐ Thyroid Disease ☐ Tuberculosis

Please list any heart conditions:_____

Is your child currently under a physician's care? Y N If yes what for:_____

Please list any medications your child is currently taking:_____

Your Child's Dental History

How many times a day does your child brush?_____ **How many times a week does your child floss?**_____

Is your child's water fluoridated? Y N

Does your child do any of the following? ☐ Thumb/Finger suck ☐ Tongue thrusting or sucking ☐ Mouth breath/snore

Please check any of the following problems that apply to your child.

☐ Sensitive tooth, teeth or gums ☐ Blisters or sores in/around mouth ☐ Red, swollen, or bleeding gums

☐ Discomfort, clicking, popping or locking j aw ☐ Loose tooth ☐ Bad breath ☐ Broken/chipped tooth/teeth

☐ Grinding teeth ☐ Ringing in ears ☐ Stained teeth

Please list any other dental symptoms your child may be experiencing:_____

If known, please list the following dates: Last Exam_____ Last X-Rays_____

Previous dentist?_____ Reason for leaving?_____

Siblings and Favorite Things

Please list any siblings your child may have and their age:_____

_____

Please list any pets your child may have and their name:_____

What is your child's favorite color?_____ What is your child's favorite book or toy?_____

What is your child's favorite hobby?_____ What is your child's favorite movie?_____

Does your child play any sports?_____

Parent/Guardian Signature:_____ Date:_____

Doctors Signature:_____ Date:_____