Welcome to our practice!

Michael J. LeBlanc
FAMILY DENTISTRY

CHILD PATIENT INFORMATION

NAME: _____ _____ _____
FIRST MIDDLE INITIAL LAST

ADDRESS: _____ APT/LOT#: _____

_____
CITY STATE ZIP

DOB: ____/____/____ SS#: ____-____-____ SEX: M F

SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN INFORMATION

MOTHER: _____ RELATION: _____
(OR RESPONSIBLE PARTY)

SS#: ____-____-____ DL#/STATE: _____ DOB: ____/____/____

ADDRESS: _____ APT/LOT#: _____
(IF DIFFERENT FROM ABOVE)

HOME PHONE: ( ) _____ WORK: ( ) _____ OTHER: ( ) _____

EMPLOYER: _____ OCCUPATION: _____

FATHER: _____ RELATION: _____
(OR RESPONSIBLE PARTY)

SS#: ____-____-____ DL#/STATE: _____ DOB: ____/____/____

ADDRESS: _____ APT/LOT#: _____
(IF DIFFERENT FROM ABOVE)

HOME PHONE: ( ) _____ WORK: ( ) _____ OTHER: ( ) _____

EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

INSURED'S NAME: _____ RELATIONSHIP: _____

DOB: ____/____/____ SS#: ____-____-____

EMPLOYER: _____ OCCUPATION: _____

SUBSCRIBER I.D.#: _____ GROUP/CONTRACT#: _____

SECONDARY INSURANCE COMPANY: _____

INSURED'S NAME: _____ RELATIONSHIP: _____

DOB: ____/____/____ SS#: ____-____-____

EMPLOYER: _____ OCCUPATION: _____

SUBSCRIBER I.D.#: _____ GROUP/CONTRACT#: _____

(CONTINUE TO BACK OF PAGE)

CHILD'S DENTAL HISTORY

FORMER DENTIST:_____ OFFICE PHONE:_____

PRACTICE NAME:_____ FAX#:_____

ADDRESS:_____

HOW OFTEN DOES YOUR CHILD: BRUSH:_____ FLOSS:_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ THUMB/FINGER SUCKING
- ☐ FINGERNAIL BITING
- ☐ GRINDING TEETH
- ☐ LIP/CHEEK BITING
- ☐ JAW DIFFICULTY (CLICKING AND OR PAIN)

CHILD'S HEALTH HISTORY(PLEASE CHECK ALL THAT APPLY):

- ☐ ACID REFLUX
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ CANCER
- ☐ CODEINE ALLERGY
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ HIV/AIDS
- ☐ HEART MURMUR
- ☐ HEPATITIS-TYPE:
- ☐ IODINE ALLERGY
- ☐ LATEX ALLERGY
- ☐ MITRAL VALVE PROLAPSE
- ☐ PENICILLIN/AMOXICILLIN ALLERGY
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ TONSILLITIS
- ☐ TUBERCULOSIS
- ☐ OTHER:

IS YOUR CHILD ALLERGIC TO ANY DRUGS, ETC.? **YES/NO** IF SO, WHAT?

_____

IS YOUR CHILD CURRENTLY BEING TREATED BY A PHYSICIAN OTHER THAN GENERAL PRACTICES? **YES/NO** IF SO, FOR WHAT?

_____

PEDIATRICIAN/FAMILY DR.:_____ PHONE:_____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? PLEASE LIST:

_____

DOES YOUR CHILD HAVE ANY HEART CONDITIONS THAT REQUIRE PRE-MEDICATION (ANTIBIOTIC) BEFORE TREATMENT? **YES/NO** IF SO, WHAT TYPE OF CONDITION?

_____

HOW DID YOU HEAR ABOUT US?:_____

ASSIGNMENT AND RELEASE:

I hereby authorize payment directly to **DR. MICHAEL J. LeBLANC** 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 dependents. I am also financially responsible for any associated collection cost, penalty fees, and/or NSF charges that may be added to my account. ***I agree I am responsible for understanding my insurance benefits, frequencies and overall eligibility.***

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.

SIGNATURE OF RESPONSIBLE PARTY:_____

DATE:_____

Our office strives to keep all records current. Please initial at each appointment to verify that the information on this sheet has been updated and is correct to the best of my knowledge:

INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____
INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____
INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____	INITIALS_____DATE_____