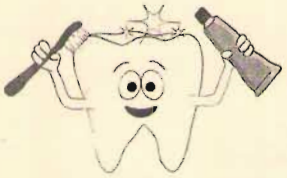

Betar Dental & Associates

Center for Dental Excellence

2217 Seventh Avenue Altoona. PA 16602

We are pleased to welcome you to our practice. Please take a few minutes to complete this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health.

Tell Us About Your Child

Today's Date:_____ Name: _____ ☐Male ☐Female

Last First MI

Birthdate:_____ Age:_____ Social Security #: _____-_____-_____

What is the primary Reason for today's visit?_____

Has any member of your family been or is currently a patient in this office? ☐Yes ☐No

-If yes, name:_____

Social History - ***Who lives at home?*** Address: _____

Mother's Information

Name_____

Mother Stepmother Guardian

Birthdate _____/_____/_____

Home Phone (_____)_____

Cell Phone (_____)_____

SS Number _____-_____-_____

Father's Information

Name_____

Father Stepfather Guardian

Birthdate _____/_____/_____

Home Phone (_____)_____

Cell Phone (_____)_____

SS Number _____-_____-_____

Are your child's parents: ☐Married ☐Single ☐Separated ☐Divorced

Custody Agreement: _____

_____

Who is Accompanying the Child Today?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Exposures/Habits

Do any household members smoke? ☐ Yes ☐ No Caretakers? ☐ Yes ☐ No Grandparents? ☐ Yes ☐ No

Does your child still require nursing, bottle or sippy cups at bedtime? ☐ Yes ☐ No

-If yes, what are the contents of the bottle _____

Is your child allergic to any foods or materials? ☐ Yes ☐ No

-If yes, please list _____

Dental History

Is your child currently in pain? ☐ Yes ☐ No Is this your child's first visit to the dentist? ☐ Yes ☐ No

Has your child experienced problems with previous dental work? ☐ Yes ☐ No

-If so, explain: _____

Previous Dentist: _____ Date of last visit:_____

Were any x-rays taken? ☐ Yes ☐ No Have there been any injuries to the teeth, face or mouth? ☐ Yes ☐ No

-If so, explain_____

Is the child's water fluoridated? ☐ Yes ☐ No Is the child taking fluoride supplements? ☐ Yes ☐ No

Does an ADULT brush his/her teeth TWICE daily? ☐ Yes ☐ No

Does an ADULT floss his/her teeth daily? ☐ Yes ☐ No

Has your child had general anesthesia? ☐ Yes ☐ No Any complications with general anesthesia? ☐ Yes ☐ No

Health History – ***Check if your child has or ever had any of the following conditions:***

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Allergies to any Drugs
- ☐ Allergy to Latex
- ☐ Anemia
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Asthma
- ☐ Autism
- ☐ Behavior Disability
- ☐ Blood Dyscrasis
- ☐ Blood Transfusion/Date
- ☐ Breathing/Lung Problems
- ☐ Cancer/Tumor
- ☐ Chicken Pox
- ☐ Congenital Birth Defects
- ☐ Congenital Heart Defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Endocrine System Disorders
- ☐ Frequent Infections
- ☐ Handicaps/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Disease/Murmur
- ☐ Hemophilia/Blood Disorders
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Fevers as Infant
- ☐ HIV Positive
- ☐ Hives
- ☐ Kidney Conditions
- ☐ Learning Disability
- ☐ Liver Conditions
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Mentally Disabled
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Physically Disabled
- ☐ Recurrent Headaches
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Sleep Apnea
- ☐ Sickle Cell Anemia
- ☐ Sight Disorders
- ☐ Significant Injuies
- ☐ Skin Rash
- ☐ Tonsilitis
- ☐ Tuberculosis

Please list any serious medical conditions your child has had: _____

_____

Please list all drugs your child is currently taking: _____

Please list all drugs the child is allergic to: _____

Child's Primary Care Physician _____ Phone (_____) _____

Primary Dental Insurance

Insurance Co. name: _____

Policy owner's name: _____

Policy owner's birthdate: _____

Membership ID #: _____

Secondary Dental Insurance

Insurance Co. name: _____

Policy owner's name: _____

Policy owner's birthdate: _____

Membership ID #: _____

Financial responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners. I understand that, if necessary, credit bureau reports may be obtained. I understand it is my responsibility to advise the office of any changes in personal/medical status.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene.

Are there any restrictions, handicaps or problems we might encounter? ☐ Yes ☐ No