North Bend Family Dentistry

~227 W 2nd Street, North Bend~
888~2330

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

PATIENT INFORMATION

Date______________________ Patient SS#________________________ Birth date __________________

Name of Minor/Child____ Sex ☐M ☐F Age____________
Last Name First Name Middle Initial

Nickname__________________ Hobbies______________________ School _________________________

Home Address____
Street City State Zip

Person financially responsible______________________ Home Phone__________ Work Phone__________

Whom may we thank for referring you?____

PARENT & INSURANCE INFORMATION

Father's/Guardian's Name _________________________

Address (if different from patient's) ________________

____

Home Phone__________Work Phone ____________
(if different from above) (if different from above)

E-mail _____________________________________

Employer ___________________________________

Soc Sec#_______________ Birth date______________

Do you have dental ins coverage for minor/child? ☐ Yes ☐ No

Ins Co ________________ Phone _______________

Address ____________________________________

Group # ____________________________________

Mother's/Guardian's Name _________________________

Address (if different from patient's) ________________

____

Home Phone__________Work Phone ____________
(if different from above) (if different from above)

E-mail _____________________________________

Employer ___________________________________

Soc Sec#_______________ Birth date______________

Do you have dental ins coverage for minor/child? ☐ Yes ☐ No

Ins Co ________________ Phone _______________

Address ____________________________________

Group # ____________________________________

DENTAL HISTORY

Date of last visit to a dentist _________________________

Has child complained about dental problems ☐ Yes ☐ No

Does child brush teeth daily? ☐ Yes ☐ No

Does child use floss every day? ☐ Yes ☐ No

For what service?_________________________________

Is fluoride taken in any form? ______________________

Any injuries to mouth, teeth, head? __________________

Any unhappy dental experiences?____________________

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? _________________

MEDICAL HISTORY

Minor/Child's Physician____________________ City/State___________________ Phone_____________

Date of last physical examination______________ Results ______________________________________

Is Minor/Child under care of physician now? ☐ Yes ☐ No

Receiving any medication or drugs? ☐ Yes ☐ No

Ever been hospitalized? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No

Is there excessive bleeding when cut? ☐ Yes ☐ No

Medications ________________________________

____

____

Allergies___________________________________

____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓)

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name______________________________ Relationship___________________ Phone__________________

Name______________________________ Relationship___________________ Phone__________________

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of ______________________________ and there are no court orders now in
Please Print Name of Minor/Child

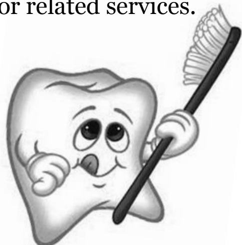
effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetic, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent is covered by insurance with ______________________ and assign directly to Dr. Galloway all
Name of Insurance Company(ies)

insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Galloway may use my minor/child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.



____ Signature of Parent, Guardian or Personal Representative

______________________ Date

____ Please print name of Parent, Guardian or Personal Representative

______________________ Relationship to Patient