

dental salon

501 W Golf Rd Suite B Schaumburg, IL 60195
847.805.6202
www.dentalsalon.com

Thank you for choosing Dental Salon for your Child/Minor's dental care. All information is kept strictly confidential. We cannot share any information you give us to a third party without your approval.

Today's Date: _____
mm/dd/yyyy

About Child/Minor

Child/Minor Name: _____
First MI Last Preferred Name

Social Security Number: _____ Date of Birth: _____ Male Female
000-00-0000 mm/dd/yyyy

Parent/Guardian Information

Please provide two contacts if possible.

-First contact

Name: _____
First MI Last Preferred Name Relationship to Child/Minor

email address: _____ Phone: _____
Mobile Other

Address: _____
Street Apt # City State Zip Code

Employer: _____ Occupation: _____

-Second contact

Name: _____
First MI Last Preferred Name Relationship to Child/Minor

email address: _____ Phone: _____
Mobile Other

Check if address is same as First Contact

Address: _____
Street Apt # City State Zip Code

Employer: _____ Occupation: _____

Insurance Information

Is Child/Minor covered under a dental insurance plan?

Insurance Company: _____ Toll Free Phone Number: _____ Group Number: _____

Which of the contact above is the subscriber? First Contact Second Contact _____

Subscriber ID Number (may be SSN): _____ Date of Birth Social Security #

How Did You Hear About Us? (please select all that apply)

Through a friend or family member
What is their Name?

First

Last

Through our TV commercial

On Comcast

On RCN

On the Internet

Google

Yahoo

Yelp

CitySearch

Facebook

Emergency Dentist 24/7

Through our dental insurance

Other

Please describe:

Dental History

Why is Child/Minor here today? _____

Date of last dental visit? _____ Who was the last dentist Child/Minor saw? Dr. _____

Has Child/Minor ever had an unpleasant dental experience? (if yes, please describe) Yes No

How is your Child/Minor's current dental health?

Good

Average

Needs Improvement

Not sure

Does Child/Minor brush teeth daily?

Does Child/Minor floss teeth daily?

Is fluoride taken in any form?

Any injuries to mouth, teeth, head?

Yes

No

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

If **Yes** to any mouth habits please circle above which and describe: _____

Health History

Child/Minor's Physicians Name: _____ Phone Number: _____ Date of Last Visit: _____

Is your Child/Minor currently under this physicians care? Yes No

If Yes, what is the purpose of the current care being provided? _____

Taking any medication or drugs? **Yes** **No**

Ever been hospitalized?

Ever had surgery?

Is there excessive bleeding when cut?

Medications: _____

Allergies: _____

Has Child/Minor ever had or do they currently have any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Measles
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Issues	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other

Any other medical conditions, please describe: _____

Has a physician or dentist ever recommended Child/Minor take antibiotics before dental treatment? Yes No

Is Child/Minor allergic or had a bad reaction to any of the following?

	Yes	No
Local anesthetic (novacaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>

Anything else (please describe): _____

I have completed the above information to the best of my knowledge. I understand that it is my responsibility as parent/guardian to inform Dental Salon if Child/Minor ever has a change in health.

Child/Minor Consent

I am the parent/guardian of _____
Print Name of Child/Minor

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize Dental Salon to perform necessary dental services for the Child/Minor named above, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor whether or not I am present when the treatment is rendered.

Insurance Assignments and Release

I certify that Child/Minor named above is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dental Salon all 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.

Dental Salon may use above named Child/Minor's health care information and may disclose such information to 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 Date Print Name Parent/Guardian Relationship to Child/Minor

