CARL JENKINS, DDS
Cosmetic, Implant, & Family Dentistry

570-538-5005
315 Main Street, Watsontown, PA

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'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

Date _____

Patient Information

Name of Minor/Child _____
Last Name First Name Middle Initial

Sex ◯ m ◯ f **Age** _____ **Birthdate** _____ **Nickname** _____ **Hobbies** _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person Financially Responsible _____ **Home Phone** _____ **Work Phone** _____

Whom may we thank for referring you? _____

Insurance

Father/Guardian's Name _____

Address (If different from patient's) _____

_____

Home Phone _____ (If different from above) **Work Phone** _____ (If different from above)

Employer _____

Soc. Sec. # _____ **Birthdate** _____

Do you have dental insurance coverage for minor/child?
◯ Yes ◯ No

Plan Name _____

Phone Number _____

Address _____

Group # _____ **Policy #** _____

Mother/Guardian's Name _____

Address (If different from patient's) _____

_____

Home Phone _____ (If different from above) **Work Phone** _____ (If different from above)

Employer _____

Soc. Sec. # _____ **Birthdate** _____

Do you have dental insurance coverage for minor/child?
◯ Yes ◯ No

Plan Name _____

Phone Number _____

Address _____

Group # _____ **Policy #** _____

Is your child eligible for treatment under Medical Assistance? ◯ Yes ◯ No

Child's Medical Assistance I.D. # _____

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? _____

Has child complained about dental problems? ◯ Yes ◯ No

Does child brush teeth daily? ◯ Yes ◯ No

Does child use floss every day? ◯ Yes ◯ No

Any Mouth Habits - Thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ◯ Yes ◯ No

Please complete both sides.

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 Medications _____

Receiving any medication or drugs? ◯ Yes ◯ No _____

Ever been hospitalized? ◯ Yes ◯ No _____

Ever had surgery? ◯ Yes ◯ No Allergies _____

Is there excessive bleeding when cut? ◯ Yes ◯ No _____

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

◯ A.I.D.S./H.I.V.	◯ 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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian _____ Date _____

I certify that my minor/child is covered by insurance with:

Name of insurance Company(ies) _____

and assign directly to Dr._____ 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 hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian _____ Date _____

Update (To be completed at a later visit)

Has there been any change in patient's health since last dental appointment? ◯ Yes ◯ No

If yes, please describe _____

Is patient taking any new medications? ◯ Yes ◯ No If yes, please list _____

Signature of Parent/Guardian _____ Date _____

Signature of Dentist _____ Date _____