

# WELCOME

**The benefits of a happy, healthy smile are immeasurable!**  
**Our goal is to help you reach and maintain maximum oral health. (Please fill out this form completely.)**  
**The better we communicate, the better we can care for you.**

## 1 ABOUT CHILD

Today's Date: \_\_\_\_\_

Name: LAST FIRST MI \_\_\_\_\_

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: / / Age: SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
APT / CONDO #

CITY STATE ZIP \_\_\_\_\_

Home Telephone #: \_\_\_\_\_

## 2 PARENTS INFORMATION

Their Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Who may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

## 3 DENTAL INSURANCE

### Primary Dental Insurance

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: / / Insured's SS #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

State law required that we obtain your consent for treatment. There are risks associated with any dental treatment. These include, bleeding, failure of wound to heal, injuries to adjacent teeth or structures, incomplete removal of tooth, dry socket, loss of teeth, loss of bone, instrument breakage, breakage of roots, retained root fragments, swallowing or aspirating of objects, allergic reactions to drugs, jaw pain, pain in opening mouth, failure of treatment to accomplish its purpose, numbness of tongue or mouth, death, and bacterial endocarditis.

I acknowledge that I have read and understand the information contained on this form. I hereby authorize the dentists, hygienists, and assistants of their choice to perform diagnostic, surgical and dental treatment. Furthermore, if I have insurance coverage, I authorize release of any information relating to insurance claims. I understand that I am responsible for all costs of dental treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or Parent if minor)

I HEREBY AUTHORIZE PAYMENT directly to Richard L. Herman DDS of the group insurance benefits otherwise payable to me.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Payment is due in full at the time of treatment unless prior arrangements have been approved.

## OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_

2. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_

3. Date \_\_\_\_\_ Comments \_\_\_\_\_ Signature \_\_\_\_\_

## 4 DENTAL HISTORY

Why have you come to the dentist today? \_\_\_\_\_

\_\_\_\_\_

## 5 MEDICAL HISTORY

Your child's physical health is:  Good  Fair  Poor

Is your child currently under the care of a physician?  No  Yes

Please explain \_\_\_\_\_

Is your child taking any prescription / over-the-counter drugs?  No  Yes

Please list each one \_\_\_\_\_

### Have you ever had any of the following diseases or medical problems?

Y N Cancer / Chemotherapy	Y N Epilepsy / Seizures / Fainting Spells
Y N Heart Murmur	Y N Diabetes / Tuberculosis (TB)
Y N Rheumatic Fever	Y N Hemophilia / Abnormal Bleeding
Y N HIV# / AIDS	Y N Ulcers / Colitis
Y N Heart Surgery / Pacemaker	Y N Congenital Heart Defect
Y N Kidney Problems	Y N Anemia / Radiation Treatment
Y N Artificial Valves	Y N Asthma / Arthritis
Y N Sinus Problems	Y N Difficulty Breathing
Y N Fever Blisters	Y N Hospitalized for Any Reason
Y N Severe / Frequent Headaches	Y N Hepatitis
Y N Psychiatric Problems	Y N Blood Transfusion

Physician's Name \_\_\_\_\_

Telephone No. \_\_\_\_\_

### Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	
Y N Erythromycin	Y N Codeine	

Please list any other drugs that you are allergic to: \_\_\_\_\_