Ching Dental Care

116 North Locust Street
Momence, IL 60954
(815) 472-6345

www.ChingDDS.com

Date _______________

Name of Minor/ Child____

Male/Female __________________ Age ______________ Birthdate____

Nickname _________________________________ Hobbies ____

Address ____

City _____________________________ State ___________ Zip Code ____

Person Financially Responsibility for Account ____

Home Phone _________________________________ Work Phone____

Whom may we thank for referring you? ____

Date of last dental visit?___________________ What services were rendered?________________________________

[Y] [N] Has child complained about any dental problems?

[Y] [N] Does child brush teeth daily?

[Y] [N] Does child floss everyday?

[Y] [N] Is fluoride taken in form?

[Y] [N] Any injuries to mouth, head, teeth?

[Y] [N] Any unhappy dental experiences?

[Y] [N] Any mouth habits? (Thumb sucking, nail biting, mouth breathing,

pacifier, sleeps with a bottle, etc?) Please explain ____

____.

Physician Name_______________________________________ Date of last visit___________________

Date of last physical______________________ Results____

[Y] [N] Is minor/ child under physician care?

[Y] [N] Is minor/child receiving any mediations/ drugs?

[Y] [N] Has minor/child ever been hospitalized?

[Y] [N] Has minor/child had surgery? Please explain____

[Y] [N] Excessive bleeding when cut?

Medications:____

Allergies: ____

Please Check All that Apply:

[Y] [N]AIDS/ HIV Positive	[Y] [N]Drug/ Alcohol Abuse	[Y] [N]Mononucleosis
[Y] [N]Anemia	[Y] [N]Epilepsy	[Y] [N]Mumps
[Y] [N]Asthma	[Y] [N]Fainting/Dizziness	[Y] [N]Rheumatic Fever
[Y] [N]Bladder Problems	[Y] [N] Hearing Problems	[Y] [N]Sinus Problems
[Y] [N]Cancer	[Y] [N] Heart Problems	[Y] [N]Thyroid Disease
[Y] [N]Cerebral Palsy	[Y] [N]Hepatitis A	[Y] [N]Tuberculosis
[Y] [N]Chicken Pox	[Y] [N] Hepatitis B or C	[Y] [N] Any thing not found above.
[Y] [N]Convulsions	[Y] [N] Kidney Disease	Please List:_______________________________
[Y] [N]Diabetes	[Y] [N] Measles	____

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

Name_________________________ Relationship________________ Phone______________________

Name_________________________ Relationship________________ Phone______________________

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I have received this practice's Notice of Privacy Practices. I certify that my minor/ child is covered by insurance with: ____ and assign directly to Ching Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I give my permission to Ching Dental Care and staff to take clinical records and/or photographs of my dental treatment for educational and instructional purposes. We ask you to show consideration by calling in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient. Kindly give a 24 hour notice by 2pm the day before your appointment or a $50 cancellation fee will be billed directly to you.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Parent/ Guardian ____ Date________________________

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