West Madison Dental

Stuart J. McCormick DDS

Welcome

www.westmadisondental.com

Your dental health and happiness are the primary goals for our team. Please accurately complete this confidential form to help these goals become a reality for you!

1 About Your Child

Today's Date: _____

Child's Name: _____
Last First Middle Initial

❑ Male ❑ Female Child prefers to be called: _____

Birth Date: ____/____/____ SS #: _____

Home Address: _____

_____
City State Zip

Home Telephone #: _____

Previous/Present Dentist: _____
(please circle)

Date of Last Dental Visit: _____

2 Parent/Guardian Info

Father's Full Name: _____

Address (if different from child's): _____

_____
City State Zip

Home Telephone #: _____

Birth Date: ____/____/____ SS #: _____

Employer: _____

Occupation: _____ How Long Held: _____

Best Time/Place to Reach: _____

E-mail Address: _____

Mother's Full Name: _____

Address (if different from child's): _____

_____
City State Zip

Home Telephone #: _____

Birth Date: ____/____/____ SS #: _____

Employer: _____

Occupation: _____ How Long Held: _____

Best Time/Place to Reach: _____

E-mail Address: _____

3 Referral Information

Are other family members currently seen in our office?

❑ No ❑ Yes *location*: _____

name of account holder: _____

How did you hear about our office?

❑ Family/Friends/Co-Workers *name*: _____

❑ Internet *website*: _____

❍ Angie's List ❍ Google Places ❍ Mynewsmile ❍ Website Search

❑ Direct Mail Piece

❑ Newspaper Advertisement ❑ Television ❑ Magazine

❑ Insurance Plan *name*: _____

❑ Other *explain*: _____

4 Primary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: __/__/__ ID/SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: __/__/__ ID/SS #: _____

Insured's Employer: _____

5 Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for my child's proper dental care.

I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my child's records to the following persons who are involved in my child's care or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my child's dental care insurance carrier or payor of dental benefits may pay less than the actual bill for services and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my child's dental care payor.

I attest to the accuracy of the information on this page.

_____

Parent's or Guardian's Signature Date

OVER →

Patient Name: _____ **Date:** _____

6 Medical History

Name of Personal Physician: _____

Address/Clinic: _____ Phone #: _____

Date of Last Visit to Any Physician: _____

Reason for That Visit: _____

List any prescription or over-the-counter medications he/she is currently taking (including herbal supplements) and dosages:

_____

Is he/she allergic to any of the following? *Please check yes or no for each.*

YES	NO		YES	NO	
❑	❑	Aspirin	❑	❑	Dental Anesthetics
❑	❑	Codeine	❑	❑	Penicillin
❑	❑	Latex	❑	❑	Tetracycline
❑	❑	Sulfa	❑	❑	Erythromycin
❑	❑	Amoxicillin	❑	❑	Food Allergies

If you are aware of any adverse reactions to other medications, he/she has had list them here: _____

Does he/she take antibiotic premedication for dental appointments?: _____

Has he/she ever had any of the following diseases or medical problems? *Please check yes or no for each item.*

YES	NO		YES	NO	
❑	❑	Arthritis	❑	❑	Joint/Bone Replacement
❑	❑	Asthma	❑	❑	Kidney Transplant
❑	❑	Blood Disease	❑	❑	Liver Disease
❑	❑	Breathing Problem	❑	❑	Low Blood Pressure
❑	❑	Cancer	❑	❑	Mental Health
❑	❑	Chemical Dependence	❑	❑	Mitral Valve Prolapse
❑	❑	Convulsions	❑	❑	Osteoporosis
❑	❑	Diabetes	❑	❑	Prolonged Bleeding
❑	❑	Dizziness	❑	❑	Radiation Treatment
❑	❑	Drug/Alcohol Abuse	❑	❑	Rheumatic Fever
❑	❑	Emphysema	❑	❑	Rheumatism
❑	❑	Frequent Headaches	❑	❑	Seizures
❑	❑	Heart Condition	❑	❑	Sinus Condition
❑	❑	Hepatitis	❑	❑	Sleeping/Snoring Problems
❑	❑	Herpes	❑	❑	Stroke
❑	❑	High Blood Pressure	❑	❑	TMJ
❑	❑	HIV	❑	❑	Tuberculosis
❑	❑	Immune Deficiency	❑	❑	Tumors/Growths
❑	❑	Jaundice			

Other medical notes: _____

Does he/she use tobacco in any form? ❑ Yes ❑ No

If so, what form? ❑ Chewing Tobacco ❑ Cigarettes

Are you taking any medications for Osteoporosis? ❑ Yes ❑ No

FEMALES

Is she taking Birth Control Pills/Patch/Injections? ❑ Yes ❑ No

Is she pregnant? ❑ Yes ❑ No Is she nursing? ❑ Yes ❑ No

7 Dental History

Has he/she ever had any serious/difficult problems with dental treatment? ❑ Yes ❑ No

If yes, please explain: _____

_____

Do his/her gums ever bleed? ❑ Yes ❑ No

Has he/she ever had:

- Orthodontic Treatment (Braces) ❑ Yes ❑ No
- Oral Surgery (Extractions) ❑ Yes ❑ No
- Periodontal Treatment (Gum Disease) ❑ Yes ❑ No
- A bite splint or mouth guard ❑ Yes ❑ No
- A serious injury to the mouth or head ❑ Yes ❑ No

Does he/she experience:

- Clicking or popping of the jaw ❑ Yes ❑ No
- Headaches, neck or shoulder pain ❑ Yes ❑ No

How many times a week does he/she floss? _____

How many times a day does he/she brush? _____

Do you assist him/her with brushing? ❑ Yes ❑ No

Other than toothpaste, does he/she take supplemental fluoride in any form? ❑ Yes ❑ No

8 Dental Future

What is the reason for today's visit? _____

_____

Is he/she currently in pain? ❑ Yes ❑ No

What would you change about his/her smile or bite, if you could?

_____

_____

Would he/she like whiter teeth? ❑ Yes ❑ No

Would he/she like fresher breath? ❑ Yes ❑ No

I understand the information I have given today is correct to the best of my knowledge. I also understand and accept my responsibility to inform this office of any changes in my/my child's medical status.

_____

Parent's or Guardian's Signature: Date

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