ERIC T. MONG, DDS
FAMILY DENTISTRY

GREENVILLE
724.588.8910
206 Main St | Greenville, PA 16125

SLIPPERY ROCK
724.421.8163
120 Franklin St | Slippery Rock, PA 16057

1. ABOUT YOUR CHILD

Today's Date: _____/_____/_____ File #:_____

Child's Name: _____
LAST FIRST MI

Child's Nickname: _____ ☐ Boy ☐ Girl

Child's Birthdate: _____/_____/_____ Age: _____ Child's SS#: _____

School: _____ Grade: _____

Child's Home Phone #: (_____) _____

Child's Address: _____

_____
CITY STATE ZIP

Referred By: _____

2. INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____ Insured's ID #: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

Does either policy cover Orthodontics? ☐ Yes ☐ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____ Insured's ID #: _____

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

Insured's Name: _____

Relation: _____ Date of Birth: _____/_____/_____

Insured's Employer: _____

3. CHILD'S FAMILY INFORMATION

Who is accompanying this child today?

_____ _____

FULL NAME (IF OTHER THAN PARENT) **RELATION TO CHILD**

Do you have Legal Custody of this child? ☐ Yes ☐ No

How many Brothers/Sisters?_____ Age(s): _____

_____ _____

MOTHER'S NAME ☐ STEP MOTHER ☐ GUARDIAN **EMAIL ADDRESS**

_____

(☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____

HOME PHONE # WORK PHONE #

_____ _____/_____/_____ _____

MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LICENSE #

Employer: _____ How Long? _____

Employer's Address: _____

_____

CITY **STATE** **ZIP**

_____ _____

FATHER'S NAME ☐ STEP FATHER ☐ GUARDIAN **EMAIL ADDRESS**

_____

(☐ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____

HOME PHONE # WORK PHONE #

_____ _____/_____/_____ _____

FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LICENSE #

Employer: _____ How Long? _____

Employer's Address: _____

_____

CITY **STATE** **ZIP**

4. ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation to child: _____

Billing Address: _____

_____

CITY STATE ZIP

_____ _____/_____/_____ _____

SOCIAL SECURITY # DATE OF BIRTH DRIVERS LICENSE #

(_____) _____ _____ (_____) _____

WORK PHONE # EXT. CELL PHONE #

Payment Method: ☐ Cash ☐ Check ☐ Credit Card – Enter card # below (if accepted)

_____ _____/_____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

INITIALS

5. CHILD'S DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is child in pain? ☐ No ☐ Yes How Long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping in jaw.	☐ Lost/Broken Filling(s)	☐ Stained teeth
☐ Red, swollen or bleeding gums.	☐ Teeth grinding	☐ Locking Jaw
☐ Sensitive tooth , teeth or gums.	☐ Ringing in Ears	☐ Bad breath
☐ Blisters/Sores in or around the mouth.	☐ Broken/Chipped tooth	

☐ Other: _____

Do child require pre-medication? ☐ Yes ☐ No ☐ Don 't know

Previous Dentist: _____ (_____) _____

NAME PHONE #

Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ☐ Yes ☐ No

How would you rate the child's smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

6. CHILD'S MEDICAL HISTORY

Is child taking any of the following medications?

☐ Pain killers (including aspirin) ☐ Ritalin ☐ Stimulants
☐ Blood thinners ☐ Tranquilizers ☐ Insulin
☐ Muscle relaxers ☐ Other(s), please list:

_____

Child's Physician: _____ (_____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE #

_____ Last Medical Exam: _____/_____/_____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur
Y N Artificial Heart Valves
Y N Blood Transfusion(s)
Y N Cancer/Tumors
Y N Abnormal Bleeding
Y N Birth Defects
Y N Tuberculosis TB
Y N Cerebral Palsy
Y N High/Low Blood Pressure
Y N Congenital Heart defect
Y N Asthma/Difficulty Breathing
Y N Liver/Kidney/Organ Problems
Y N Jaw Problems TMJ/TMD
Y N Artificial Bones/Joints/Implants
Y N Fainting/Seizures/Epilepsy
Y N Scarlet Fever
Y N Tonsillitis
Y N Surgeries/Operations
Y N Leukemia/Anemia
Y N Hemophilia
Y N Cleft Lip/Palate
Y N Hepatitis
Y N Hyper Active/ADD
Y N Rheumatic fever
Y N Respiratory Problems
Y N Diabetes/Hypoglycemia
Y N Chemotherapy
Y N Hearing Problems
Y N HIV+/AIDS/ARC
Y N Psychiatric Problems

Please list any other medical condition(s) the child has or ever had: _____

_____

Is Child allergic to any of the following? ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin
☐ Dental Anesthetics (Novocaine) ☐ Food Allergies ☐ Others: _____
Please rate the child's general health from 1-10: _____ Does Child wear contact lenses? ☐ Yes ☐ No
Has this child ever taken the drug Ritalin? ☐ No ☐ Yes/How long? _____ Child's blood type: _____
Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
INITIALS

Signature _____ Date: _____/_____/_____
☐ Parent or Guardian ☐ Other

OFFICE USE ONLY

Dentist's Signature: _____