ERIC T. MONG, DDS
FAMILY DENTISTRY

724.588.8910
408 S. Main St. | Greenville, PA 16125

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
INITIALS
services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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

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: ______________________________________