We would like to welcome you and your child to our practice! Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach healthy oral habits that will enable your child to have a beautiful smile that lasts a lifetime.

About Your Child

Name_____ Date of Birth_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone _____ Social Security Number_____

Other family members at this office ❑ yes ❑ no_____

Referred by_____

About You

Name_____ Check here if address same as above ❑ yes

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell/Pager)_____

Relationship to Child_____

Financial Information

Primary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Secondary Insurance Carrier

Employed By_____ Dental Ins. Co._____

Employee_____ Employee Date of Birth_____

Employee SSN_____ Union/Local #_____ Group #_____

Person Responsible for Paying This Account (if different than above)_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____ (Cell/Pager)_____

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. Therefore, it is your responsibility to know your individual coverage. Failing to do so will result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between the insurance company and your dentist. Payment is required at the time of service; however, if insurance is involved, payment will be expected on the copay. On major work, at least half payment is required at time of service. **If for any reason insurance does not pay in a reasonable time, payment will be expected from the patient.**

Most importantly, we are here to help in any way we can, and look forward to meeting your dental needs. Again, welcome to our practice.

I accept and understand the patient responsibilities outlined above:

Parent or Guardian_____ **Date**_____

Medical / Dental History

Has your child ever had any of the following medical conditions or problems (please circle all that apply)

Heart Murmur	Heart problems of any kind	Convulsions/Epilepsy	Diabetes
Rheumatic Fever	HIV/AIDS	Hemophilia	Bleeding disorders
Hearing Impairment	Hyperactivity (ADD/ADHD)		

Food Allergies If yes, what type?_____

Cancer If yes, what type?_____
Did he/she receive radiation / chemotherapy? (circle those that apply)

Any operations?_____
Any stays in the hospital?_____

Are there any medical conditions or problems relating to your child that need further explanation?

_____
_____

Physician's name_____Telephone_____
Approximate date of last visit_____
Please rate your child's mental health Good Fair Poor
Is your child allergic to any medications? ❑ yes ❑ no
If yes, please list_____
Is your child currently taking any prescription medications? ❑ yes ❑ no
If yes, please list_____

Does your child need to be premedicated before dental treatment? ❑ yes ❑ no
Has your child been to the dentist before? ❑ yes ❑ no
If yes, the approximate date of last visit?_____
Are there any dental problems that you are aware of at present? ❑ yes ❑ no
If yes, please explain_____
Does your child brush his/her teeth daily? ❑ yes ❑ no
Please rate your child's oral health. Good Fair Poor

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

Name_____Relationship_____

Phone_____Phone #2_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services that my child may need.

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Parent or Guardian_____Date_____

Witness_____Date_____

Doctor_____Date_____

Medical history updates

Initial/Date _____ _____ _____ _____ _____ _____ _____

Brighton Family Dentistry PLLC
Brian J. Petersburg DDS
Brian K. Giammalva DDS

8641 West Grand River Suite 6 Brighton MI 48116
810.227.4224 Fax 810.227.4660
www.brightonfamilydentistry.com