John A. Ritchie D.D.S.

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. All information provided is confidential.

PATIENT INFORMATION

Child's name		Soc. Sec. #	
Address			
City	State	Zip	Phone
Sex □ M □ F	Birthdate		Age
Contact person	Relation to child		
Address *(if different from child)*			
Email	Home Phone	Cell Phone	Business Phone
How did you discover our practice?	□ Street Sign	□ Christian Blue Pages	□ Yellow Pages □ Internet/Web site
	□ Referred by:		
	□ I am a previous patient of Dr Ritchie		□ Other:

PRIMARY INSURANCE

Is this child covered by Dental Insurance? □Y □ No		Subscriber's Name	
Relation to Child	Soc Sec #		Insured's Birthdate
Address *(if different from child)*			
City	State	Zip	Home Phone
Cell Phone	Email		
Employed by		Occupation	
Business Address		Business Phone	
Insurance Company		Phone	
Contract #	Group #	Subscriber #	
Name of other dependents under this plan			

ADDITIONAL INSURANCE

Is this child covered by Additional Insurance? □Y □ N			
Subscriber Name			
Relation to Child	Soc Sec #		Insured's Birthdate
Address *(if different from child)*			
City	State	Zip	Home Phone
Cell Phone	Email		
Employed by		Business Phone	
Insurance Company		Phone	
Contract #	Group #	Subscriber #	
Name of other dependents under this plan			

Please complete both sides ☺

DENTAL HISTORY

How can we help your child today?

Former Dentist | Address | Phone

Date of last dental visit | Date of last x-rays

What type of dental care did your child receive during their last visit to the dentist?

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □Y □ N If yes, describe

Is your child experiencing any dental pain or discomfort? □Y □ N

Has your child ever experienced a mouth injury? □Y □ N

How many sodas does your child consume (on average) per week?_____

Are you concerned about the amount of candy your child consumes? □Y □ N

Child's habits affecting the mouth or teeth: □Thumb sucking □ Nail biting □ Smoking □ Uses smokeless tobacco products □ Excessive gum chewing

Are you aware of your child having any specific dental problems or need for treatment that Dr Ritchie should know about? □Y □ N If yes, describe

MEDICAL HISTORY

Child's Physician | Date of last medical checkup

Address | Phone

Does your child's physician require that your child take antibiotics before dental procedures? □ Y □ N If yes, which one?

Has your child had any serious illnesses or operations? □Y □ N If yes, describe

Is your child currently under physician's care? □ Y □ N If yes, describe

Check (√) yes or no whether your child has had any of the following diseases or conditions:

□ Y □ N Cough up blood	□ Y □ N Hemophilia/ Abnormal bleeding	□ Y □ N Shortness of breath	□ Y □ N Anemia
□ Y □ N Hepatitis/Jaundice		□ Y □ N Sinus problems	□ Y □ N Prolonged healing
□ Y □ N Diabetes	□ Y □ N Asthma	□ Y □ N AIDS/HIV positive	□ Y □ N Immunization, current
□ Y □ N Skin Rash	□ Y □ N Rheumatic fever	□ Y □ N Seasonal allergies	□ Y □ N Fainting spells
□ Y □ N Headaches	□ Y □ N Tuberculosis	□ Y □ N Mitral Valve prolapse	□ Y □ N Material allergies
□ Y □ N Kidney disease	□ Y □ N Liver disease	□ Y □ N Thyroid disease	(latex, wool, metal, chemicals)
□ Y □ N Chicken Pox	□ Y □ N Hearing Impairment	□ Y □ N Tonsillitis	□ Y □ N Seizures/Epilepsy
□ Y □ N Heart Murmur	□ Y □ N Tuberculosis	□ Y □ N Persistent cough	□ Y □ N Cold sores/Herpes
□ Y □ N Respiratory disease	□ Y □ N Blood disease	□ Y □ N Cancer	□ Y □ N Heart disease
Describe:_____	Describe:_____	Describe:_____	Describe:_____

Does your child have any disease, condition or problem not listed above that Dr Ritchie should know about? □ Y □ N If yes, describe

List medications your child is taking:

Is your child sensitive or allergic to any of the following:

Penicillin □ Y □ N Novocaine □ Y □ N Codeine □ Y □ N

Aspirin □ Y □ N Other antibiotic/drug □ Y □ N_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr Ritchie to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform Dr Ritchie. As the parent or legal guardian of this underage patient, I authorize Dr Ritchie and his staff to provide dental care for this child.
My signature on this form also authorizes the following:

- The insurance company indicated on this form to pay to Dr Ritchie all insurance benefits otherwise payable to me for services rendered and the use of this signature on all insurance submissions.
- Dr Ritchie to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature: Date:

Patient's portion of payment is due in full at time of treatment, unless prior arrangements have been approved.