

## CHILD ACQUAINTANCE FORM

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M( ) F ( )  
First Last

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone # \_\_\_\_\_

**Parent Information:**

Father's Name \_\_\_\_\_ DL# \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Employer \_\_\_\_\_ Work phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ DL# \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Employer \_\_\_\_\_ Work phone # \_\_\_\_\_

**Insurance Information:**

Insured's Name \_\_\_\_\_ SS # \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Insurance Co's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Group # \_\_\_\_\_

**Method of Payment:**

Check \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card \_\_\_\_\_  
 Person responsible for account \_\_\_\_\_

**Whom may we thank for referring**

Your family to our office? \_\_\_\_\_ Relationship \_\_\_\_\_

### MEDICAL HISTORY

- |  |     |    |                    |     |    |
|--|-----|----|--------------------|-----|----|
| 1. Is your child in good health?   | Yes | No |                    |     |    |
| 2. Has your child had regular medical checkups?                              | Yes | No |                    |     |    |
| 3. Has your child had any surgical operations?                               | Yes | No |                    |     |    |
| If yes, what? _____  |     |    |                    |     |    |
| 4. Has your child ever been put to sleep for medical or dental treatment?    | Yes | No |                    |     |    |
| 5. Are your child's immunizations up to date?                                | Yes | No |                    |     |    |
| 6. Does your child take any medications on a regular basis?                  | Yes | No |                    |     |    |
| If yes, list _____   |     |    |                    |     |    |
| 7. Has your child ever had an unfavorable reaction to any medicine or food?  | Yes | No |                    |     |    |
| If yes, list _____   |     |    |                    |     |    |
| 8. Please check if your child has or had problems with any of the following: |     |    |                    |     |    |
| Heart  | Yes | No | Diabetes           | Yes | No |
| Heart murmur   | Yes | No | Kidney problems    | Yes | No |
| Rheumatic fever  | Yes | No | Liver/ Hepatitis   | Yes | No |
| Lungs  | Yes | No | Excessive bleeding | Yes | No |
| Asthma   | Yes | No | HIV/ AIDS          | Yes | No |
| Allergies  | Yes | No | Seizures           | Yes | No |
| Tuberculosis   | Yes | No | Nervous disorder   | Yes | No |

9. How much does your child weigh? \_\_\_\_\_ pounds

# CHILDRENS DENTAL HISTORY

- |     |   |     |    |
|-----|---|-----|----|
| 1.  | Is this your child's first visit to the dentist?                                  | Yes | No |
| 2.  | When was the last visit to the dentist? _____                                     |     |    |
| 3.  | What was done at the last dental visit? _____                                     |     |    |
| 4.  | Has your child ever had a bad experience with a dentist?                          | Yes | No |
| 5.  | Does your child take fluoride supplements or vitamins w/fluoride?                 | Yes | No |
| 6.  | Have there been any injuries to your child's teeth or jaws?                       | Yes | No |
| 7.  | Does your child have or had any of the following dental problems?                 |     |    |
|     | Cavities                      Yes    No                      Sensitive To:        |     |    |
|     | Toothaches                Yes    No                      Hot                      | Yes | No |
|     | Crooked Teeth            Yes    No                      Cold                      | Yes | No |
|     | Discolored Teeth        Yes    No                      Sweets                     | Yes | No |
| 8.  | Does or has your child had any of the following habits?                           |     |    |
|     | Thumb Sucking            Yes    No                      Lip Biting                | Yes | No |
|     | Nail Biting                Yes    No                      Finger Biting           | Yes | No |
|     | Pacifier                    Yes    No                      Bottle                 | Yes | No |
| 9.  | What is the reason for your visit today? _____                                    |     |    |
| 10. | Please list any questions or concerns you may have about your child's oral health |     |    |

## CONSENT

I grant permission to the doctor to do all such things as are necessary to diagnose, treat and care for the dental needs of my child. Treatment will not be performed without first consulting the child's parent or legal guardian. All children (under age 18) must be accompanied by parent or legal guardian for the duration of all their dental visits.

In order to give your child our full attention we request that you remain in the reception area while treatment is performed. If your child is not cooperative, we may suggest sedation or referral to a pediatric specialist. However, you will be charged an office visit for the time spent with your child.

I understand that my insurance company may pay less than the actual bill for services and that I am fully responsible for payment of my account. By signing this statement I agree to pay for any and all services not paid, in whole or in part by my dental insurance company/payer and any legal fees incurred to enforce this statement. I hereby authorize the release of any information relating to insurance claims for my child's dental services. I also authorize payment of my group insurance benefits directly to Esthetique Dental. I certify that the information I have provided here is true and correct, and I understand and agree to the consent provisions.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Dentist Signature \_\_\_\_\_

For information, concerns, or complaints about your dental care contact:  
 State Board of Dental Examiners  
 333 Guadalupe, Tower 2, Suite 800  
 Austin, TX 78701  
 (512) 463-6400



ESTHETIQUE DENTAL  
Family and Cosmetic Dentistry

**OFFICE POLICY**

In an effort to keep health care costs down while maintaining a high level of professional care, we have established the following financial policies for payment of treatment.

1. Your co-payment is due in full at the time of treatment for each visit unless prior arrangements have been made with our Office Manager. We accept cash, checks, debit cards, Visa, MasterCard, Discover, and American Express.
2. We file your insurance as a courtesy. We do not assume responsibility if your insurance company does not pay on your filed claim.
3. We will accept payment from your insurance company. Current insurance information must be on file and updated at each visit. **THE PATIENT IS RESPONSIBLE FOR ANY NON-COVERED OR UNPAID INSURANCE BALANCE AFTER 30 DAYS FROM THE DATE OF TREATMENT.** Any treatment not paid by your insurance for any reason is your responsibility.
4. If unable to keep your appointment, please notify the office within 48 hours. Failure to do so will result in a broken appointment charge of \$50.00.
5. Any radiographs taken in the office are property of Esthetique Dental. There is a \$25.00 fee for any duplication of x-rays.
6. There is a \$35.00 service fee for returned checks.

I have read and I understand the above office policies and I agree to the terms.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date