George H. Bullard D.D.S.

Bullard Children's Dentistry LLC

Date Completed: _____

General Patient/Child Information

Child's Full Name: _____ Preferred Name: _____ Male Female

Child's Birthdate: _____ Child's Age: _____ Phone: _____

Child's Address: _____

Siblings Seen Here: _____

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Mother/Female Guardian Information

Name (Last, First, Middle): _____

Social Security #: _____ Birthdate: _____ Marital Status: Married Single Divorced Widowed

Address (street, city, state, zip): _____

Phone Numbers: Home: _____ Cell: _____Work: _____

Email Address: _____ Employer: _____ Occupation: _____

Father/Male Guardian Information

Name (Last, First, Middle): _____

Social Security #: _____ Birthdate: _____Marital Status: Married Single Divorced Widowed

Address (street, city, state, zip): _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email Address: _____ Employer: _____ Occupation: _____

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Billing/Other Information

Person Responsible for Account: _____ Relationship to Child: _____

Billing Address (if different from parent/guardian) _____

Phone Numbers (if different from parent/guardian) Home: _____ Cell: _____

Who is accompanying the child today? _____ Relationship to Child: _____

Do you have legal custody of child? Yes No

Other information we should know: _____

Dental Insurance Information

Primary Insurance: Insurance Company: _____ Policy Holder Name: _____

Secondary Insurance: Insurance Company: _____ Policy Holder Name: _____

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**Payment for services is required at the time of visit. As a courtesy, we will file your insurance for you; however, the account must be cleared within 30 days. For your convenience, we accept cash, check, money order, Care Credit, and MasterCard or Visa. Please feel free to discuss your child's treatment and fees with our office.

I HAVE READ THE ABOVE POLICY: Signature _____

Dental History

*What brought you to our office today?_____

_____

*Whom may we thank for referring this patient?

_____

*Is this your child's first visit to the dentist? Yes No

If not, date of last dental visit: _____

*Name of previous dentist: _____

*Were x-rays taken at previous dental office? Yes No

If yes, when were the x-rays taken: _____

*Has your child had any problems with medical/dental visits?

_____

*Have there been any injuries to your child's teeth or jaw? Yes No

If yes, please explain: _____

_____

*Please circle if you child has a history of:

Breastfeeding Bottle Fed Pacifier Thumb/Finger sucking

Teeth grinding/clenching Pain in jaw joints

Home Care Information

*Is your home supplied by well water? Yes No

If yes, does your child currently take a fluoride supplement? Yes No

*How often does your child brush his/her teeth?

_____

*Does your child brush their teeth alone? Yes No

If yes, does someone still supervise while they brush? Yes No

If yes, who supervises the child? _____

*Has flossing been introduced at home? Yes No

If yes, how often: _____

☺ Healthy Smiles Start Here ☺

Health History

***Family physician or pediatrician:**

_____

*Has your child had or been diagnosed with any of the following?

Please circle all that apply:

Allergies to Anesthesia Allergies to Medicines Anemia

Asthma Autism Spectrum ADD/ADHD Bleeding Disorders

Cancer Cerebral Palsy Contagious Disease Diabetes

Down's Syndrome Epilepsy Heart Problems Hepatitis

HIV Virus/AIDS Latex Allergy Kidney/Liver problems

Measles Mumps Nervousness Pre-Med Needed

Psychiatric Care Rheumatic Fever Scarlet Fever Stroke

Sinus Problems Typhoid Fever Tonsillitis Tuberculosis

Allergies to: _____

_____

*Does your child have health problems that require the active care of a physician? Yes No

If yes, please explain: _____

_____

*Is your child currently taking medications? Yes No

If yes, please list: _____

_____

*Has your child ever been hospitalized? Yes No

If yes, please explain: _____

_____

*Because your child is a minor, your signature as a parent/guardian must be obtained to authorize any necessary dental service. I hereby grant such authorization, and shall accept responsibility for any and all fees incurred for such dental services.

Signature_____Date_____

Office Use Only	**Medical History Reviewed**
Date/Initials_____	Date/Initials_____
Date/Initials_____	Date/Initials_____
Date/Initials_____	Date/Initials_____
Date/Initials_____	Date/Initials_____
Date/Initials_____	Date/Initials_____