JAMES C. PALMER, D.D.S.

729 W. MAIN • HOMER, LA 71040
Phone (318) 927-6152 • Fax (318) 927-5200
www.jamescpalmerdds.com
appointments@jamescpalmerdds.com

1 Tell Us About Your Child

Today's Date: _____ Nickname: _____

Child's Name: _____
LAST FIRST MI

E-mail Address: _____

Birthdate: _____ Age: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies / Sports: _____

Child's Home #: _____

Child's Mailing Address: _____
APT/CONDO #

_____
CITY STATE ZIP

2 Who is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is your child adopted? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List brothers / sisters with age:

Previous Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

3

☐ **Mother's Information** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____

Wk #: _____ Ext: _____ Hm #: _____

Cell #: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

Email Address: _____

SS #: _____ DL #: _____

☐ **Father's Information** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____

Wk #: _____ Ext: _____ Hm #: _____

Cell #: _____

Employer: _____

How Long at Current Job: _____ Job Title: _____

Email Address: _____

SS #: _____ DL #: _____

4 Person Responsible For Account

Name: _____ Relation: _____

Mailing Address: _____

_____
CITY STATE ZIP

Hm # _____ DL #: _____

Employer: _____

Wk # _____ Ext: _____ SS #: _____

Cell # _____

Who is responsible for making appointments?

Name: _____

Wk #: _____ Ext. _____ HM #: _____

Cell # _____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

6

Why did you bring your child to the dentist today?

Has your child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone # _____ Date of Last Visit: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has your child ever taken Fosamax, Actonel Boniva or any other bisphosphonate? ☐ Yes ☐ No

Please describe your child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking:

Please list all drugs / things that your child is allergic to:

Y N Latex Y N Metals/Nickel Y N Plastics

7

Has your child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Hearing Impairment
Y	N	ADD / ADHD	Y	N	Heart Murmur
Y	N	Anemia	Y	N	Hemophilia
Y	N	Any Hospital Stays	Y	N	Hepatitis
Y	N	Any Operations	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hives/Skin Rash
Y	N	Asthma	Y	N	Kidney / Liver Problems
Y	N	Cancer	Y	N	Learning Disability
Y	N	Chicken Pox	Y	N	Lupus
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions / Epilepsy	Y	N	Psychiatric Issues
Y	N	Diabetes	Y	N	Rheumatic / Scarlet Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Sickle Cell Disease/traits
Y	N	Handicaps / Disabilities	Y	N	Tuberculosis (TB)

Please discuss any medical problems that your child has had:

8

Has your child ever experienced any of the following?

Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrust

Neighbor or Relative not living with you.

Name _____ Phone _____

Address _____

_____

CITY STATE ZIP

9

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.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____

Signature of parent or guardian Date

I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment. Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY**

Medical History Update

1. Date: _____

Comments:

_____

SIgnature

2. Date: _____

Comments:

_____

SIgnature

3. Date: _____

Comments:

_____

SIgnature

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY**