Jeremy J. Larson, DMD LLC
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(541) 567-8229

Welcome to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Date _____ Patient ID _____

Your Child

Name _____ Date of Birth _____ Sex ☐ M ☐ F
Last Name First Name Middle Initial

Address _____ City _____ State _____ ZIP _____

SSN _____ Age _____ Phone _____ School _____ Grade _____

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

Who is responsible for making appointments? _____

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Responsible Party

Name _____ Date of Birth _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ ZIP _____

Phone _____ Cell Phone _____ Email _____

Driver's License # _____ Relationship _____ SSN _____

☐ ***Mother*** ☐ *Stepmother* ☐ *Guardian*

Name _____ SSN _____
Last Name First Name Middle Initial

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ Driver's Licence # _____

☐ ***Father*** ☐ *Stepfather* ☐ *Guardian*

Name _____ SSN _____
Last Name First Name Middle Initial

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ Driver's Licence # _____

Primary Insurance

Insured's Name _____ Relationship to Patient _____
Last Name First Name Middle Initial

Date of Birth _____ SSN _____ Phone _____

Subscriber Employer _____ Occupation _____ Phone _____

Employer Address _____ City _____ State _____ ZIP _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ ZIP _____ Phone _____

Secondary Insurance

Insured's Name _____ Relationship to Patient _____
Last Name First Name Middle Initial

Date of Birth _____ SSN _____ Phone _____

Subscriber Employer _____ Occupation _____ Phone _____

Employer Address _____ City _____ State _____ ZIP _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ ZIP _____ Phone _____

Child's Habits

How often does your child brush? _____ How often does your child floss? _____

Child's Former Dentist _____ Date of last visit _____

Address _____ City _____ State _____ ZIP _____ Phone _____

Child's Physician _____ City _____ State _____

Is your child's water fluoridated? □ Yes □ No Does your child take fluoride supplements? □ Yes □ No

Does your child:

□ Suck thumb/finger □ Suck/Bite lips □ Bite/Chew nails

□ Chew hard objects (pencils, etc.) □ Grind teeth □ Clench jaws

Health History

Has your child had difficulty with previous dental visits? _____

Does your child have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)? □ Yes □ No

Has your child ever taken Fen-Phen/Redux? □ Yes □ No

Has your child ever had any of the following?

□ Asthma □ Hemophilia □ Congenital Heart Defect □ Abnormal Bleeding

□ Cancer □ Diabetes □ Handicaps/Disabilities □ Heart Murmur

□ Hepatitis □ Allergies □ Convulsions/Epilepsy □ HIV/AIDS

□ Rheumatic Fever □ Tuberculosis

Please explain any medical problems that your child has _____

_____

_____

_____

MEDICATIONS (List medications your child is currently taking)

_____

_____

_____

ALLERGIES

_____

_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that may dental insurance my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments: _____

_____

_____

_____