



Jessie M. Banks D.D.S., P.L.L.C.
Specializing in Children, One Smile at a Time

Date: ____/____/____

Patient Name: _____ Nickname _____

Address: _____ City: _____

Home Phone: _____ Zip Code: _____ Gender M F

Social Security Number: _____ Birth date: _____ Age: _____

Mother's Name: _____ Date of Birth ____/____/____ SS# _____

Employer _____ Work Phone _____ Cell Phone _____

Father's Name: _____ Date of Birth ____/____/____ SS# _____

Employer _____ Work Phone _____ Cell Phone _____

How did you hear about us? _____

INSURANCE INFORMATION

PLEASE PRESENT THE FRONT DESK WITH A COPY OF YOUR CURRENT ID CARD

Name of Insured _____ Employer: _____

DOB ____/____/____ SS# ____-____-____

Insurance Carrier _____ Group # _____

Who has Legal custody of this patient? _____

What is the reason for your child's visit today? _____

HEALTH HISTORY

Name of child's Physician _____ Date of last physical exam _____

Y N Is your child in good health?

Y N Has your child ever had a health problem?

List _____

Y N Has your child ever been hospitalized or had any surgical procedure performed?

Please give reason and dates? _____

Y N Is your child allergic to any medications or foods (latex, penicillin, bananas)?

Please List _____

Y N Is your child currently taking any medications?

Please list medication & reason _____

Y N Were there any problems at birth? Weight at Birth? ____ lb ____ oz

List _____

Do you consider your child's development & learning to be (please circle): advanced normal slow

Please circle if your child has been treated for any of the following:

- | | | | | |
|---------------------|-----------------------------|--------------------|---------------------|------------------|
| Heart Disease | Bleeding/Blood Transfusions | Asthma | LATEX allergy | Autism PPD |
| Mental Delays | Down Syndrome | Speech/hearing | Seizure/Epilepsy | Cleft lip/palate |
| Eyes/vision | Cerebral palsy | Congenital defect | Personality/ Social | Heart Murmur |
| Recurrent Headaches | Cancer/Tumors | Frequent Infection | Tubes/Ear Infection | Genetic disorder |
| Physical Delays | Hepatitis | Adopted | Foster Child | Other Problems |

PLEASE ELABORATE ON ANY ITEMS CIRCLED:

Names & Ages of Siblings _____

Child's Hobbies, Pets & Interests _____

Favorite Snacks Foods _____

School _____ Grade _____

DENTAL HISTORY

Y N Has your child ever been to the dentist? Name of previous dentist and date: _____

Y N Has your child experienced any unfavorable experiences or reactions to previous dental care?

Please explain: _____

Y N Does your child suck a finger, thumb, or pacifier? _____

Y N Is your child having any dental pain? Location of pain: _____

Y N Are you & your child happy with your child's smile?

Describe your concerns: _____

Y N Is your child active in sports? List: _____

Y N Does your child wear an athletic mouth guard while playing sports?

Was your child: Breast fed Bottle fed At what age was it discontinued? _____

Does your child use a "sippy cup"? Y N If yes, what does your child prefer to drink: _____

Who brushes your child's teeth? _____

Please circle if your child is having problems with any of the following:

Cavities

Toothache/Pain

Sensitive Teeth

Trauma

Gum Infections

Color of teeth

Orthodontics/Crowding

Jaw Sounds

Other

COMMENTS: _____

FLUORIDE HISTORY

Y N Is your home water supply fluoridated?

Y N Does your child use fluoride toothpaste?

Y N Do you give your child any other forms of fluoride?

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Banks & her staff to examine, clean, and provide dental treatment on my child's teeth. I further request & authorize the taking of dental x-rays as may be considered necessary by Dr. Banks to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Banks & her staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation & demonstration of procedures & instruments, & using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that the estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any to be made directly to Dr. Jessie M. Banks

Signature _____ Date _____

I give my permission for the following adults to accompany my child to future dental appointments & make treatment decisions concerning my child when I am not present.

NAME _____ PHONE _____ RELATIONSHIP _____

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