



Welcome

Smiles by... Dr Garland Watson

We are pleased to welcome you and your child to our practice.



WATSON
orthodontics

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Patient Information

Date: _____ SS/HIC/Patient ID Number: _____ Birthdate: _____

Name of Minor/Child: _____ Sex: M F Age: _____
Last Name First Name Middle Initial

Nickname: _____ Hobbies: _____ Cell phone: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

School Name: _____ School phone: _____

Person Financially Responsible: _____ Home Phone: _____ Work phone: _____

Whom may we thank for referring you? _____

Parent/Guardian Information

Father's/Guardian's Name: _____	Mother's/Guardian's Name: _____
Address: _____ <small>(If Different from patient's)</small>	Address: _____ <small>(If Different from patient's)</small>
Home Phone: _____ <small>(If Different from patient's)</small>	Home Phone: _____ <small>(If Different from patient's)</small>
Work phone: _____ <small>(If Different from patient's)</small>	Work phone: _____ <small>(If Different from patient's)</small>
E-mail: _____	E-mail: _____
Employer: _____	Employer: _____
Soc. Sec #: _____	Soc. Sec #: _____
Birthdate: _____	Birthdate: _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> yes <input type="checkbox"/> No
Plan Name: _____	Plan Name: _____
Phone: _____	Phone: _____
address: _____	address: _____
Group #: _____	Group #: _____
Policy #: _____	Policy #: _____
is your child eligible for treatment under medical assistance? <input type="checkbox"/> yes <input type="checkbox"/> No	is your child eligible for treatment under medical assistance? <input type="checkbox"/> yes <input type="checkbox"/> No
Child's medical assistance#: _____	Child's medical assistance#: _____

Dental History

dentist Name: _____ Date of last visit? _____

	yes	No		yes	No
Has child complained about dental problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily?.....	<input type="checkbox"/>	<input type="checkbox"/>	any injuries to mouth, teeth, head?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss everyday?.....	<input type="checkbox"/>	<input type="checkbox"/>	any unhappy dental experiences?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?.....	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>





Medical History

Minor/Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical examination: _____ Results: _____

	yes	No	
Is Minor/Child under care of physician now?.....	<input type="checkbox"/>	<input type="checkbox"/>	medications: _____
Receiving any medication or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies: _____
Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
is there excessive bleeding when cut?.....	<input type="checkbox"/>	<input type="checkbox"/>	

has the minor/child had any history of or difficulty with any of the following? if yes, please check (4).

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.v. | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> chicken pox | <input type="checkbox"/> fainting | <input type="checkbox"/> liver disease | <input type="checkbox"/> sinus problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> convulsions | <input type="checkbox"/> hearing problems | <input type="checkbox"/> measles | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> bladder problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> heart problems | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> drug/alcohol abuse | <input type="checkbox"/> hepatitis | <input type="checkbox"/> mumps | <input type="checkbox"/> other |

Emergency Contact

Name: _____ relationship: _____ Phone: _____

Name: _____ relationship: _____ Phone: _____

Authorizations

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

Signature of Parent, Guardian or Personal Representative

Date

Please Print Name of Parent, Guardian or Personal Representative

Relationship to Patient

