Donald L. Hardee, DDS, PA

Family, Esthetic, and Implant Dentistry
215 Commerce Street | Greenville, NC 27858
Phone 252-756-6626 ~ Fax 252-756-2147

1. ABOUT YOUR CHILD

Today's Date ____________ Child's Name ______________________________
LAST FIRST MI

Child's Nickname ______________________ Boy Girl Birthdate ________ Age _____ SS# ____________

Child's Address ______________________________
CITY STATE ZIP

Child's Home Phone ______________________

School ______________________________ Grade ____________

Referred By ______________________________

2. INSURANCE INFORMATION

Primary Dental Insurance

Co. Name ______________________

Address ______________________
CITY STATE ZIP

Phone Number ______________________

Insured's ID# ______________________

Group # (Plan, Local, Policy#) ______________________

Insured's Name ______________________

Relation ____________ Date of Birth ____________

Insured's Employer ______________________

Secondary Dental Insurance

Co. Name ______________________

Address ______________________
CITY STATE ZIP

Phone Number ______________________

Insured's ID# ______________________

Group # (Plan, Local, Policy#) ______________________

Insured's Name ______________________

Relation ____________ Date of Birth ____________

Insured's Employer ______________________

3. CHILD'S FAMILY INFORMATION

Who is accompanying child today? ______________________________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have legal custody of this child? Yes No How many Brothers/Sisters? ________ Age(s) ____________

Mother's Name ______________________________ STEPMOTHER GUARDIAN

Birthdate ____________ Age ________ SS# ____________

Mother's Address ______________________________
CITY STATE ZIP

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email ____________ Employer ______________________

Employer's Address ______________________________

Father's Name ______________________________ STEPFATHER GUARDIAN

Birthdate ____________ Age ________ SS# ____________

Father's Address ______________________________
CITY STATE ZIP

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email ____________ Employer ______________________

Employer's Address ______________________________

4. ACCOUNT INFORMATION

Person ultimately responsible for account:

Name ______________________________ Relation ____________

Billing Address ______________________________
CITY STATE ZIP

(Continued on back.)

(Continued from front.)

SS# ______________________ Work Phone ______________________

__________ INITIAL I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

5. DENTAL INFORMATION

Reason for today's visit Exam Emergency Consultation

Is your child in pain? No Yes How long? ______________________

Please check any of the following problems:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Bad Breath
Blisters/Sores in or around mouth	Sensitive Teeth/Gums	Ringing in Ears
Teeth grinding/Locking jaw	Broken/Chipped Tooth	Red, swollen or bleeding gums

Other ______________________

Does child require any pre-medication? Yes No Don't Know

Previous Dentist ______________________ Phone Number ______________________

Last Dental Exam ______________________ Last Dental X-rays ______________________

Times a day your child brushes? ________ Times a week your child flosses? ________ What type of tooth bristles do you use? Soft Medium Hard

Is your child in braces? Yes No How Long? ______________________ Please rate your child's smile from 1-10 ________

6. MEDICAL HISTORY

Is child taking any of the following medications? (Please Check)

Insulin Ritalin Pain Killers (including Aspirin) Muscle Relaxers Stimulants Tranquilizers

Others (please list) ______________________

Does child have or ever had any of the following diseases, medical conditions, or procedures?

Y N Heart Murmur	Y N Birth Defects	Y N Cancer/Tumors	Y N Artificial Bones/Joints/Implants
Y N Rheumatic Fever	Y N Chemotherapy	Y N Cerebral Palsy	Y N Liver/Kidney/Organ Problems
Y N Surgeries/Operations	Y N HIV+/AIDS/ARC	Y N Hepatitis	Y N Fainting/Seizures/Epilepsy
Y N Hearing Problems	Y N Respiratory Problems	Y N Anemia	Y N Abnormal Bleeding Problems
Y N Tonsilitis	Y N Fever Blisters/Ulcers	Y N Asthma	Y N High/Low Blood Pressure
Y N Artificial Heart Valves	Y N Tuberculosis TB	Y N Leukemia	Y N Diabetes/Hypoglycemia
Y N Blood Transfusion(s)	Y N Cleft Lip/Palate	Y N Hyper Active/ADD	Y N Psychiatric Problems
Y N Congenital Heart Defect	Y N Scarlet Fever	Y N Difficulty Breathing	
Y N Hemophilia	Y N Jaw Problems TMH/TMD		

Please list any other medical conditions child has or ever had ______________________

Is child allergic to any of the following? Latex Penicillin/Amoxicillin Tetracycline Dental Anesthetics (Novocain)

Foods ______________________ Others ______________________

Please rate your child's general health from 1-10 ________ Does child wear contact lenses? Yes No

Does child do any of the following? Thumb/Finger Sucking Tongue Thrusting/Sucking Heavy Snoring Mouth Breathing Lip Sucking/Biting

Child's Physician ______________________ Phone Number ______________________

Physician's Address ______________________ Last Medical Exam ________

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________ Date ________

Parent/Guardian Other (Relationship ______________________)