Charles A. Puntillo DDS, LTD.

Welcome to our dental home!
We promise to provide you with the best possible dental care. Please let us know if we can help you in any way.

• Patient Information • *(DEPENDENT)*

Patient name:______________________________ Prefer to be called:______________
Birth date:______________ School:______________________________
Home address:______________________________ City:__________ State:_____ Zip:_______
Home phone: ______________ Cell phone:______________ Work phone:______________
Email address:______________________________
What is the best way to contact you? Home_____ Cell_____ Email_____ Work_____ Other__________
Mother's name:______________________ SSN:______________ Birth date:______________
Employer:______________________________ Occupation:______________
Father's name:______________________ SSN:______________ Birth date:______________
Employer:______________________________ Occupation:______________
In the event of an emergency, whom should we contact?______________________________
Phone(s):______________________________ Relationship______________
Previous dentist:______________________________ Date of last visit:______________
Whom may we thank for referring you?______________________________

• Insurance Information •

It is our pleasure to prepare the necessary forms to help you obtain your benefits from your insurance company. Each fee is individual for the individual patient. We provide services based on what we believe are best for you.

Primary Dental Insurance Information:
Name of insured:______________________________ Relationship:______________
Insured's date of birth:______________________________ SSN:______________
Dental insurance company:______________________________ Insurance phone:______________
Insurance co. address:______________________________
Subscriber number:______________________________ Group number:______________
Employer name:______________________________

Secondary Dental Coverage Information:
Name of insured:______________________________ Relationship:______________
Insured's date of birth:______________________________ SSN:______________
Dental insurance company:______________________________ Insurance phone:______________
Insurance co. address:______________________________
Subscriber number:______________________________ Group number:______________
Employer name:______________________________

I authorize the release of any information concerning my advice and/or treatment provided for the purpose of evaluating and/or administering claims for insurance benefits.

I authorize the use of this signature on all insurance submissions and I authorize payment of insurance benefits directly to Dr. Puntillo.

I understand that my dental insurance carrier may pay less than the actual bill for services and that I am responsible for payment of services not paid by my insurance provider.

I agree that a service charge of 1.5% per month, 18% APR, will be added to balances over 60 days past due.

PARENT/GUARDIAN SIGNATURE:______________________________ **DATE**:__________

—Turn over for more information—

• Child's Medical & Dental History •

Has the child had any history of, or conditions related to, any of the following:

☐ ADD/ADHD	☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle Cell
☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (Teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other___________

Please list the name and phone number of the child's physician:

Name of Physician:______________________________ Phone:______________________

#	Question	Yes	No
1.	Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time?__________	☐	☐
	If yes, please list: ______________________________		
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: __________	☐	☐
3.	Is the child allergic to anything else such as certain foods? If yes, please explain: __________	☐	☐
4.	How would you describe the child's eating habits? ______________________________		
5.	Has the child ever had a serious illness? If yes, when? __________ Please describe: __________	☐	☐
6.	Has the child ever been hospitalized?	☐	☐
7.	Does the child have a history of any other illnesses? If yes, please list:__________	☐	☐
8.	Has the child ever received general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech difficulties?	☐	☐
11.	Has the child ever had a blood transfusion?	☐	☐
12.	Is the child medically, mentally, or emotionally impaired?	☐	☐
13.	Does the child experience excessive bleeding when cut?	☐	☐
14.	Is the child currently being treated for any illnesses?	☐	☐
15.	Has the child had any problem with dental treatment in the past?	☐	☐
16.	Has the child ever had dental X-rays?	☐	☐
17.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
18.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
19.	Has the child had any orthodontic treatment?	☐	☐
20.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered Water		
21.	**Does the child take fluoride supplements?**	☐	☐
22.	**Does the child use fluoride toothpaste and/or fluoride rinse?**	☐	☐
23.	How many times are the child's teeth brushed per day? __________ When are the teeth brushed? __________	☐	☐
24.	Does the child suck his/her thumb, fingers or pacifier; clench or grind teeth; and/or bite fingernails, chew on pencils, etc.?	☐	☐
25.	Does the child participate in active recreational activities?	☐	☐

I authorize Dr. Puntillo to perform diagnostic procedures and treatment, including the use of local anesthetic, as may be necessary for proper dental care. I give Dr. Puntillo consent to use nitrous oxide (laughing gas) per my request.

To the best of my knowledge, the patient and medical information is complete and correct.

PARENT/GUARDIAN SIGNATURE:______________________________ **DATE**: __________

I certify that there have been no health changes except as noted below:

Date __________Change ____________________ Signature ____________________
Date __________Change ____________________ Signature ____________________
Date __________Change ____________________ Signature ____________________