Dr. Melissa McHenry DDS, MSD
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Zionsville, IN 46077
(317)873-4186

Zionsville Pediatric Dentistry
Dr. Melissa McHenry

Date:_____

Tell Us About Your Child

Child's Name:_____Date of Birth:_____ Sex: M / F

_____ _____ _____ _____
Street Address City State Zip

Home Phone:_____

Nickname: _____ School:_____Grade: _____

Who is Accompanying the Child Today?

Name: _____ Relation:_____

Do you have legal custody of the child? Yes / No

Is the child adopted? Yes / No

Is the child in a foster home? Yes / No

Whom may we thank for referring you?_____

Other sibllng(s) seen by us?_____

Parents

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

Mother

Name: _____Home Phone:_____

_____ _____ _____ _____
Street Address City State Zip

Social Security#: _____ Date of Birth:_____

Employer: _____ Work Phone #:_____

Father

Name: _____Home Phone:_____

_____ _____ _____ _____
Street Address City State Zip

Social Security#: _____ Date of Birth:_____

Employer: _____ Work Phone #:_____

Insurance Information

PRIMARY COVERAGE

Dental Coverage Yes / No Orthodontic Coverage Yes / No

Name of Insured: _____ Relation to Child:_____

Social Security Number of Insured: _____ Date of Birth:_____

Employer Name: _____Address:_____

Insurance Co. Name:_____ Phone#:_____

Insurance Co. Address:_____

Street City State Zip

Group I.D. #:_____

SECONDARY COVERAGE

Dental Coverage Yes / No Orthodontic Coverage Yes / No

Name of Insured: _____ Relation to Child:_____

Social Security Number of Insured: _____ Date of Birth:_____

Employer Name: _____Address:_____

Insurance Co. Name:_____ Phone#:_____

Insurance Co. Address:_____

Street City State Zip

Group I.D. #:_____

Dental History

What is the primary reason for today's visit?_____

Is the child in pain? Yes / No

Previous / Present Dentist: _____ Date of last visit: _____ Date of last x-rays? _____

Why did you leave your previous Dentist?_____

What did you like most about your previous Dentist? _____Least?_____

Was the previous dental experience positive or negative? Explain:_____

Is the primary source of water consumed by the child fluoridated? Yes / No

Is (was) the child breast-fed or bottlefed? _____Until what age? _____

How often does your child brush their teeth? Once or twice daily? _____

How often does your child floss? Zero or Once Daily? _____

Does your child: *(circle if yes)*

Suck Thumb / Finger	Tongue Thrust	Use Pacifier
Suck / Bite Lips	Bite / Chew Nails	Have Speech Problems or Impairment
History of Traumatic Injury	Tongue / Cheek Chewing	Clench / Grind Teeth
Mouth Breathe	History of T MJ/TMD	

Medical History

Are Immunizations Current? Yes / No

Child's Physician: _____ Phone: (___) _____ Date Last Seen: _____

Address:_____

Street *City* *State* *Zip*

Is the child currently under the care of a physician? Yes / No Please explain?_____

Please list all medications that your child is currently taking: _____

Please list all drug allergies and/or other reactions: _____

Has the child had the following: *(circle if yes)*

Sickle Cell, Carrier or Trait?	Abdominal Bleeding/Hemophilia	AIDS / HIV+
Allergies / Latex Allergy	Anemia	Hospital Stays / Operations
Asthma/Lung Problems	Blood Transfusions	Cancer/Tumor
Cerebral Palsy	Congenital HearUBirth Defect	Convulsions/Seizures/Epilepsy
Cystic Fibrosis	Diabetes	Eating Disorder
Frequent Infections	Hearing/Sight Impairments	Heart Murmur
GI System Problems	Hepatitis/Liver Problems	Hives
Kidney Problems	Behavioral/Learning Problems	Tonsillitis
Tuberculosis (TB)		

If yes, to any. please explain:_____

Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE - The full balance of treatment is due at the time service is rendered. Payment plans are not available from our office. For your convenience we accept cash, check, Care Credit, Master Card, and Visa.

Assignment of Dental Insurance Benefits. Our office files insurance benefits as a courtesy. Claims unpaid by your insurance co. after 60 days are your responsibili ty and will be due in full. All deductibles, co-payments. and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and I or refuse to file claims.

Service Charges - A rebilling fee of $3.00 may be applied to accounts with balances unpaid within 30 days of the statement date. A $25.00 fee will apply to all returned checks. A fee of $25.00 will be charged for appointments cancelled with less than 24 hours notice. Our office reserves the right to pursue any other remedy by law.

Delinquent Accounts - Account balances that exceed 90 days may be pursued through third party collections. All expenses incurred in the collection process will be the account holder's responsibility. Delinquent accounts will incur a charge of 8% interest.

How will you be paying?: **CASH / CHECK / MASTER CARD / VISA / CARE CREDIT**

Circle One

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. II will be held in confidence and it is my responsibility to inform this office of changes in my child's medical status. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Zionsville Pediatric Dentistry, P.C. all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

Mother

_____ _____

Signature of Parent or Guardian *Date*

Father

_____ _____

Signature of Parent or Guardian *Date*