Harbor Dental Teen Information

Thank you for choosing our office as your dental healthcare provider. Please complete the following form to assist us in getting to know you and in providing your dental services.

Patient name:_____ Preferred name:_____ Date of birth:_____ Sex: M F

Home Address:_____ City_____State_____ Zip:_____

Parent /Guardian name:_____ Date of birth:_____ Sex: M F Marital Status:_____

Address (if different than above)_____ Email:_____

Home phone:_____ Cell:_____ Work Phone:_____ **Confirm at**: H W Cell Email Text

Individual & cell # of who will pay account_____Relationship to Patient:_____

Alternate Emergency Contact:_____ Phone:_____ Relationship to child:_____

Primary dental insurance:_____Employer_____ Group#_____

Subscriber's name:_____ Date of birth: _____ ID/SS#_____

Secondary dental insurance:_____ Employer_____ Group#_____

Subscriber's name:_____ Date of birth: _____ ID/SS#_____

Referred by: ( ) Family/friend:_____ ( ) Coworker:_____
( ) Harbor Dental Website ( ) Google/Online reviews ( ) Ins Co List/ Ins Website ( ) Sign/Drive by Location
( ) Past Patient of Harbor Dental ( ) Dex online/ phonebook ( ) Other _____

Teen Dental Health History

Yes ( ) No ( ) Is this your child's first visit to the dentist? If no, name of previous dentist or clinic_____

Date of last visit _____ What was done? _____

Does (did) your child have any of the following that might affect oral health?

Yes ( ) No ( ) Abcesses (Gum boils)
Yes ( ) No ( ) Finger or thumb sucking habits
Yes ( ) No ( ) Injury to front teeth
Yes ( ) No ( ) Bleeding gums
Yes ( ) No ( ) Stained teeth
Yes ( ) No ( ) Cold sores (fever blisters)

Yes ( ) No ( ) Clenching or grinding teeth
Yes ( ) No ( ) Toothaches
Yes ( ) No ( ) Mouth breathing
Yes ( ) No ( ) Pacifier use
Yes ( ) No ( ) Pop or sugar beverage drinking
Yes ( ) No ( ) Bad breath

Yes ( ) No ( ) Does your child have a speech problem?
Yes ( ) No ( ) Is your water fluoridated at home?
Yes ( ) No ( ) Were any teeth (baby or permanent) removed by extraction? If so, why?_____
Yes ( ) No ( ) If teeth were extracted, was it suggested that the space be maintained?
Yes ( ) No ( ) Has your child had any unfavorable dental experience? Explain_____

Yes ( ) No ( ) Other children in family? If so, how many ? ____
Yes ( ) No ( ) Are you on well water?

By signing this form:

1. I authorize the release of my dental records necessary to process insurance claims. **2**.I understand that I am primarily responsible for all charges and fees, whether ultimately covered by insurance or not. Lack of insurance coverage, even if submitted for payment, does not relieve me of responsibility for all charges. **3.** I understand that finance charges are applied to accounts 90 days past due and I agree to pay any such charges applied to my account.

Parent or Guardian Signature:_____ Date:_____