Phone: 806.792.2288
Fax: 806.792.2768

6102 82nd St., Ste. 2, Lubbock, TX 79424
info@double-t-smiles.com

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____ Biological Sex at Birth: Female o Male o

Name & age of siblings who are current patients: _____

CONFIDENTIAL RESPONSIBLE PARTIES

Mother o Stepmother o Guardian o Name: _____

Marital Status: _____ Date of Birth: _____ SS #: _____

Address: _____

Primary Phone #: _____(Home / Work / Mobile) Alt. Phone #: _____(Home / Work / Mobile)

Email Address: _____ Driver's License #: _____

Father o Stepfather o Guardian o Name: _____

Marital Status: _____ Date of Birth: _____ SS #: _____

Address: _____

Primary Phone #: _____(Home / Work / Mobile) Alt. Phone #: _____(Home / Work / Mobile)

Email Address: _____ Driver's License #: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship to patient: _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____ Date of Birth: _____ SS #: _____

Relationship: _____ Employer: _____

Employer Phone #: _____ Employer Address: _____

Insurance Co.: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

SECONDARY/ADDITIONAL DENTAL INSURANCE

Insured's Name: _____ Date of Birth: _____ SS #: _____

Relationship: _____ Employer: _____

Employer Phone #: _____ Employer Address: _____

Insurance Co.: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

PATIENT'S PHYSICIAN(S)

Family Physician / Pediatrician: _____ Phone #: _____Date of last visit: _____

Specialty Care Provider(s) & Phone Number(s): _____

Date completed: _____

Double T Smiles - Pediatric Dentistry

How did you hear about us? _____

MEDICAL QUESTIONAIRRE

Please provide an explanation for any positive (yes) responses.

YES	NO	DIAGNOSED MEDICAL CONDITIONS
		ADHD (Attention deficit hyperactivity disorder):
		Allergies to food, medicine or latex (specify):
		Asthma (triggers):
		Autism spectrum disorder:
		Anxiety / Depression:
		Bleeding Disorder:
		Bone or Skeletal Condition:
		Cancer:
		Cardiac (heart) conditions:
		Developmental Delay:
		Diabetes:
		Eczema / Skin Conditions:
		GERD / Gastrointestinal Conditions:
		Immune Conditions:
		Kidney / Liver Conditions:
		Obstructive Sleep Apnea (OSA):
		Epilepsy / Neurologic Conditions:
		Sickle Cell Disease, Trait:
		Thyroid Conditions:
		Other:

Please list all prescribed and over-the-counter medications:

_____

Please list all prior surgeries/hospitalizations:

_____

Does your child…	YES	NO
Have any habits? (thumb sucking, pacifier, going to bed with a bottle?)		
Grind or clench teeth?		
Experience frequent ear or throat infections?		
Snore or breathe through his/her mouth?		
Participate in sports?		
Use tobacco products (dip, cigarettes, vape, e-cig, hookah?)		
Use alcohol?		

I authorize the dentist to perform diagnostic procedures (exam, x-rays, cleaning) and treatment as may be necessary for proper dental care. I understand that responsibility for full payment of dental services is mine, and is expected when services are rendered, unless other arrangements have been made in advance. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand there will be a $30.00 charge for all returned checks, in addition to my account becoming a *cash only account.* I understand there may be a $100.00 collection fee for any balance turned over to an outside collection agency. I understand that an appointment is a time reserved for my child and failure to show for this appointment inconveniences other children who need urgent dental care. If I fail to show for my appointment or cancel with less than 24 hours' notice, I will be charged a fee of $25.00. Multiple missed appointments will result in dismissal from the practice. I attest to the accuracy of the information on this form.

Parent/Guardian Signature: _____ **Date**: _____