Robert V. Johnson, D.M.D., M.S., F.A.A.P.D.
1775 Glenview Road, Suite 215 Glenview, Illinois 60025
Phone: 847.729.6300 • Fax: 847.729.6351
info@righttrackdental.com • www.rightrackdental.com

We welcome your child into our practice and we will try to make his/her dental experience very pleasant.
Please complete this form carefully; this information is of great value in helping us better understand your child.

PATIENT INFORMATION

Child's Name _____ **Nickname** _____

Birthdate _____ **Age**_____ **Height** _____ **Weight** _____

School _____ **Grade** _____

Names and ages of any siblings _____

Name of child's pet or toy _____**Hobbies and/ or sports activities** _____

Child's physician/pediatrician _____ **Phone** _____

Physician's address _____ **Town** _____ **Zip** _____

Parent's general dentist _____ **Phone**_____

Dentist's address _____ **Town** _____ **Zip**_____

Dental insurance ☐**Yes** ☐**No. If yes, Name of Insurer** _____

Insurer's address _____ **Group No.** _____ **Policy No.** _____

Additional dental insurance coverage? ☐ **Yes** ☐ **No. If yes, Name of Insurer** _____

Whom may we thank for the referral to this office? _____

Address (if known) _____ **Zip**_____

Purpose of this visit _____

PATIENT'S FAMILY INFORMATION

Father's/Guardian's Name _____ **Birthdate** _____ **Social Security No.** _____

Address _____**Town** _____ **Zip** _____

Employer _____ **Address** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address: _____(Email will not be shared outside this office)

Mother's/Guardian's Name _____**Birthdate** _____**Social Security No.** _____

Address _____**Town** _____ **Zip** _____

Employer _____ **Address** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address: _____(Email will not be shared outside this office)

Individual responsible for this account: _____

How will this account be paid? ☐ **Cash** ☐ **Check** ☐ **Credit / Debit Card**

CHILD'S MEDICAL / DENTAL HISTORY

Please choose Yes or No for each question below and mark or describe any applicable conditions.
Continue your answers on the back or a separate sheet if needed or you wish to provide more information that may help our office.

1. **Is your child in good health?** ☐ Yes ☐ No
2. **Does your child have a history of** ☐ **epilepsy,** ☐ **cerebral palsy,** ☐ **heart defects,** ☐ **rheumatic fever,** ☐ Yes ☐ No
   ☐ **severe allergies,** ☐ **diabetes,** ☐ **asthma,** ☐ **kidney/liver disorders,** ☐ **other:** _____
3. **Any medications currently being taken?** (Please list) _____ ☐ Yes ☐ No
4. **Any allergies to medications including antibiotics?** (Please list) _____ ☐ Yes ☐ No
5. **Is there a history of** ☐ **thumb/finger sucking, or** ☐ **pacifier usage past 1-1/2 years of age?** ☐ Yes ☐ No
6. **Was your child** ☐ **bottle or** ☐ **breast fed? At what age was he switched to solid foods?** _____ ☐ Yes ☐ No
7. **Has your child had tonsils/adenoids removed? When was the surgery?** _____ ☐ Yes ☐ No
8. **Does your child have frequent ear/throat infections or has he or she had myringotomies (tubes in ears)?** ☐ Yes ☐ No
9. **Has your child had hearing: loss or speech impairments?** (If yes, explain) _____ ☐ Yes ☐ No
10. **Is your child adopted?** ☐ Yes ☐ No
11. **Do any parents have a history of numerous cavities (i.e. more than four teeth)?** ☐ Yes ☐ No
12. **Is there a family history of** ☐ **bad bites,** ☐ **missing teeth, or** ☐ **extra teeth'?** (If yes, please explain below) ☐ Yes ☐ No
    _____
13. **Was your child** ☐ **early (3 mos. old),** ☐ **average (6-8 mos. old), or** ☐ **late (12 mos. and older) when getting his/her baby teeth?** ☐ Yes ☐ No
14. **Has your child had a past unpleasant experience at a medical or dental office?** (Please explain below) ☐ Yes ☐ No
    _____
15. **Is your child** ☐ **nervous,** ☐ **high-strung, or** ☐ **hyperactive?** ☐ Yes ☐ No
16. **Are there specific dental problems or toothaches we should know about right now?** (If yes, please explain below) ☐ Yes ☐ No
    _____
17. **Has your child had previous dental treatment?** ☐ Yes ☐ No
    If yes, were X-rays taken and when? _____
    If yes, please name the dentist and give his/her address: _____
18. **Has your child had** ☐ **retainers,** ☐ **braces, or** ☐ **spacers?** (Mark any that apply)
19. **Does the child live with both his/her father, mother, parents or legal guardian(s)?** (If no, please explain) ☐ Yes ☐ No
    _____
20. **Have you previously completed this form for another child?** ☐ Yes ☐ No
    If yes, please give that child's name: _____
    If yes, when was s/he last seen by us?_____
21. **Is there any additional information you feel we should know? If yes, please let us know below:** ☐ Yes ☐ No
    _____

OUR OFFICE POLICIES

APPOINTMENTS: Each appointment represents a specific amount of time reserved for your child's dental care. If a problem arises so that you are unable to keep this time, we request a 48 hour notification for any cancellations. A charge will be made for any failed office visits without prior notice.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish the persons responsible to know that all professional services are charged directly to them, and that they are responsible for all fees at the time those services are rendered (unless other arrangements have already been made with our office). By utilizing our office computers, we will be able to assist you in obtaining the maximum benefits from your dental coverage. Insurance benefits from those carriers with whom we are partnered will be paid directly to the office. We ask that ALL dental insurance information be brought at your child's first visit so that we may submit a claim through our computer program. It is also the responsibility of the parent or guardian to provide our office with updated insurance information as the situation may warrant. For your convenience, we partner with numerous insurance carriers.

ACCOUNTING: Unless other arrangements have been made with our front office staff, we ask that payment be made for services rendered in one of the following ways: full payment by cash, check or money order at the time of the office visit; payment by Visa, MasterCard or Discover cards (V/MC debit cards); extended monthly payment plan on accounts over $300.00; open account with payment expected 10 day from the treatment visit. (Please note that for accounts over 45 days past due, a finance charge of 1.8% or 21% per annum will be assessed.)

CONSENT: Because your child is a minor, it becomes necessary that signed permission be obtained from a parent or guardian before any necessary dental treatment is performed. The signature of the parent or guardian affixed below authorizes the completion of all agreed upon dental treatment, and the use of those method thereto. This consent shall remain in force and effect until cancelled be either party. Furthermore, the signee will be responsible for any bill incurred during this child's dental treatment. Our office, in turn, will comply to the regulations stated in the Health Insurance Portability and Accountability Act (HIPAA). The privacy of your child's medical, dental and family records is of paramount importance in our practice.

SIGNATURE_____ **DATE**_____