Stroud Pediatric Dentistry

Robert Casey Stroud, D.D.S. – Michael L. Ball, D.D.S.
134 El Chico Trail., Suite 101, Willow Park, TX 76087
Office: 817-441-2425 Fax: 817-441-2491 www.brushflosswin.com

Date _____

Patient's Name _____ **Age** _____ **Date of Birth** _____/_____/_____
☐ **Male** ☐ **Female** **Weight** _____ **Nickname** _____
Your Name _____ **Relationship to Child** _____
Child's Physician _____
Name of school attending _____ **Grade** _____
Do we see other children in the family? ☐ **yes** ☐ **no**
Other children in family (names/ages) _____
Whom may we thank for referring you? _____

HEALTH INFORMATION:

☐ ADD/ADHD	☐ Asthma	☐ Autism	☐ Blood Disorder
☐ Cancer/Tumors	☐ Cleft Lip/Palate	☐ Diabetes	☐ Epilepsy/Seizures
☐ Emotional Issues	☐ Hearing Disorder	☐ Heart Issue/Murmur	☐ Hepatitis
☐ HIV/AIDS	☐ Kidney Disorder	☐ Liver Disorder	☐ Lung Disorder
☐ Mental Disorder	☐ Pregnancy	☐ Rheumatic/Scarlet Fever	☐ Sinus Issues
☐ Speech Issues	☐ Thyroid Disorder	☐ Tuberculosis	☐ Vision Problems

☐ **Other** _____
Please explain any above checked (if necessary):
_____
Is your child allergic to any of the following? ☐ **Latex** ☐ **Red Dye** ☐ **Penicillin**
☐ **Other Antibiotic (list type)** _____ ☐ **Nut (list type)** _____
☐ **Other allergy (specify)** _____
Is your child currently taking any medications? ☐ **yes** ☐ **no**
If yes, please list _____
Has your child ever been hospitalized or had any surgical procedures? ☐ **yes** ☐ **no**
If yes, explain _____
Are immunizations up-to-date? ☐ **yes** ☐ **no**

DENTAL INFORMATION:

Is this your child's first dental visit? ☐ **yes** ☐ **no**
If no - Date last seen _____ **Location** _____
Has your child had an unfavorable dental experience? ☐ **yes** ☐ **no**
If yes, please explain _____
Has your child had or currently have a toothache? ☐ **yes** ☐ **no**
If yes, please explain _____
Has your child ever had an oral habit? ☐ **Thumb/finger sucking** ☐ **Pacifier** ☐ **Other** _____
Does your child ever grind their teeth? ☐ **yes** ☐ **no** **Explain** _____
How do you expect your child to do today? ☐ **Good** ☐ **Fair** ☐ **Poor**
Please let us know of any special concerns or important information that you feel would help us take better care of your child _____
_____

Signature _____ **Date** _____

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PATIENT ACCOUNT INFORMATION

Date _____ **Child(ren)'s Name(s)** _____

_____

Child(ren)'s Address _____

City_____ **State**_____ **Zip** _____

Emergency Contact _____ **Phone #** _____

MOTHER'S INFORMATION: ☐ **Mother** ☐ **Stepmother** ☐ **Legal Guardian**

Name _____ **DOB** _____ **SS#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Mobile Phone** _____

Employer _____ **Position** _____

Work Phone _____ **Driver's License #** _____

Email _____ **Mother's Dentist** _____

FATHER'S INFORMATION: ☐ **Father** ☐ **Stepfather** ☐ **Legal Guardian**

Name _____ **DOB** _____ **SS#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Mobile Phone** _____

Employer _____ **Position** _____

Work Phone _____ **Driver's License #** _____

Email _____**Father's Dentist:** _____

Person Responsible for Account: _____

Dental Insurance? ☐ **yes** ☐ **no**

The undersigned hereby authorizes Stroud Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services using methods deemed appropriate for the care of the above named child(ren). The consent shall remain in force and effect until cancelled by either party.

I understand that I am responsible for the full cost of dental treatment for the above child(ren) regardless of insurance coverage.

I understand that I am responsible for notifying this office of any accidents, major illnesses or change in medical history of the above named child(ren).

Print Name _____ **Date** _____

Signature _____ **Relationship** _____

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INSURANCE INFORMATION

Date _____ **Child(ren)'s Name(s)** _____

In order to file your insurance all information must be provided.

Primary Dental Insurance

Insured's Name _____ **DOB** _____/_____/_____
Insured's Address (if different from child) _____
_____
Relationship to patient _____ **SS#** _____
Employer _____ **Work Phone** _____
Occupation _____ **Employee ID #** _____
Insurance Company _____**Group #** _____
Insurance Company Phone # _____
Insurance Company Address _____
_____

Secondary Dental Insurance

Insured's Name _____ **DOB** _____/_____/_____
Insured's Address (if different from child) _____
_____
Relationship to patient _____ **SS#** _____
Employer _____ **Work Phone** _____
Occupation _____ **Employee ID #** _____
Insurance Company _____**Group #** _____
Insurance Company Phone # _____
Insurance Company Address _____
_____

Assignment of Benefits

In consideration of services rendered, I hereby transfer and assign to: Robert Casey Stroud, DDS, PC 134 El Chico Trl., Ste. 101 Willow Park, Texas 76087 all rights, title and interest in any payment due me services as provided in the policy or policies of insurance held to me. I agree to pay Robert Casey Stroud, DDS, PC the charges which exceed the amount paid by the policies held by me. I further agree and authorize the above named office to release any information requested by the insurance company(s) or its representatives. The undersigned accepts full responsibility for the account.

Policy Holder or Authorized Agent: _____**Date:** _____