_____

Today's Date

Welcome to our Practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits, which will help, keep their smile beautiful for their lifetime.

Your Child

Child's Name_____

Nickname_____ Sex_____

E-mail_____

Birthdate_____ Age_____

Social Security No._____

School_____ Grade____

Child's home address_____

City, State, Zip_____

Phone_____

Mother Stepmother Guardian

Name_____

Cell Phone_____

Home Phone_____

Work Phone_____

Social Security No. _____

Employer_____

Occupation_____

Father Stepfather Guardian

Name_____

Cell Phone_____

Home Phone_____

Work Phone_____

Social Security No. _____

Employer_____

Occupation_____

Parent's Marital Status

Single Married Divorced Widowed Separated

Responsible Party

Name_____

Home Phone_____

Work Phone_____

Primary Dental Insurance

Insurer's Name_____

Relationship_____

Birthdate_____

Social Security No. _____

Employer_____

Insurance Company_____

Group No. _____

Employee No. _____

Ins. Co. Address_____

_____

CHILD'S HEALTH HISTORY

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits? yes no

Comments:

Has your child ever had any of the following:

Asthma	yes	no
Cancer/Hepatitis	yes	no
HIV/AIDS	yes	no
Hemophilia	yes	no
Diabetes	yes	no
Allergies/Sinus	yes	no
Congenital Heart Defect	yes	no
Handicapped/Disabilities	yes	no
Convulsions/Epilepsy	yes	no
Tuberculosis	yes	no
Psychiatric/Psychological Care	yes	no
Attention Deficit	yes	no
Chemical Dependency	yes	no
Abnormal Bleeding	yes	no
Heart Murmur	yes	no
Type:		
Rheumatic Fever	yes	no
Surgery	yes	no

Please explain any medical problems that you child has:

Child's Habits

How often does your child brush?

How often does your child floss?

Date of last dental visit:

Previous Dentists:

Child's Physician:

Physician's Phone Number:

Child's Birthdate:

Is your child's water fluoridated?	yes	no	don't know
Does your child take fluoride supplements?	yes	no	

Does your child:

Suck thumb/finger	yes	no
Suck/bite lip	yes	no
Bite/chew nails	yes	no
Chew hard objects (pencils, etc.)	yes	no
Grind teeth	yes	no
Clench jaws	yes	no

Dr. Winker's Review

Date Signed Dr.

I understand the above information is necessary to provide my dependent with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my dependents health or medication.

Parent/Guardian Signature_____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Wade Winker to submit claims for payment for services to the insurance companies of my behalf and assign to him the group insurance benefits otherwise payable to me. I understand that I am responsible for any charges not covered by my insurance benefits.

Parent/Guardian Signature_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
   (Name of Patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-½ % late charge (18% APR) may be added to my account.

Parent/Guardian Signature_____ Date_____ Relationship to Patient _____

Wade G. Winker, D.D.S., P.A.
15 W. Atwater Avenue
Eustis, FL 32726
(352) 357-2564

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgment *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

_____

_____

_____