Lakeview
DENTISTRY OF CHARLEVOIX, PC
(231) 547-4347
Melissa S. Makowski, D.D.S. • Family and Cosmetic Dentistry
109 W. Hurlbut • Charlevoix, MI 49720

We strive to make your child's visits pleasant and comfortable. Please fill out this form completely **in ink.**

Your Child

Child's Name ______________________ M ❑ F ❑ Age _____ Date ____________

Nickname ____________ Soc. Sec.# ______________ Birthdate ______________

School ______________________ Grade ______________

Child's Home Address ______________________________

City, State, Zip ______________________ Home Phone ______________

Parent or Guardian Information

❑ Mother ❑ Father ❑ Step Parent ❑ Legal Guardian

Name ______________________________

Home Phone ____________ Cell Phone ____________ Work Phone ______________

Employer ______________ ____________ Occupation ______________

Social Security # ______________________ DL # ______________

Marital Status ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Who is responsible for making appointments? ______________________________

Responsible Party *(If different from above)*

Name of Person Responsible for the Account ______________ Relationship to Patient ______________

Address ______________________ Home Phone ______________

Driver's License # ______________ Birthdate ____________ Financial Institution ____________

Employer ______________ Work Phone ____________ SS# ______________

Is this person currently a patient in our office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment. ❑ Cash ❑ Personal Check ❑ Money Order ❑ VISA ❑ MasterCard ❑ Care Credit ❑ Discover

Insurance Information

Name of Insured ______________________ Relationship to Patient ______________

Soc. Sec.# ______________ Birthdate ____________ Home Phone ______________

Name of Employer ______________ Union or Local # ________ Work Phone ______________

Employer Address ______________ City ____________ State ________ Zip ____________

Insurance Co. ______________ Group # ____________ Policy ID # ______________

Ins. Co. Address ______________ City ____________ State ________ Zip ____________

Do you have any additional dental insurance? ❑ Yes ❑ No If yes, complete the following.

Name of Insured ______________________ Relationship to Patient ______________

Soc. Sec.# ______________ Birthdate ____________ Home Phone ______________

Name of Employer ______________ Union or Local # ________ Work Phone ______________

Employer Address ______________ City ____________ State ________ Zip ____________

Insurance Co. ______________ Group # ____________ Policy ID # ______________

Ins. Co. Address ______________ City ____________ State ________ Zip ____________

Dental/Medical 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.

How often does your child brush? ______________________________

How often does your child floss? ______________________________

Is your child's water fluoridated?	❑ Yes	❑ No
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

Date of Last Dental Visit ______________________________

Previous Dentist ______________________________

Address ______________________________

Has your child had difficulty with previous dental visits? ❑ Yes ❑ No

Has your child ever had any of the following:

Asthma	❑ Yes	❑ No
Handicaps/Disabilities	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No
Abdominal Bleeding	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Stomach, Liver or Kidney Problems	❑ Yes	❑ No
Convulsions/Epilepsy	❑ Yes	❑ No

Child's Physician ______________________________ Phone # ______________________________

Address ______________________________

Previous Hospitalizations/Surgeries/Serious Illnesses When?

______________________________ ______________________________

Is your child currently taking any medications? ❑ Yes ❑ No (if yes, please list)

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Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ❑ Yes ❑ No

(if yes, please describe) ______________________________

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ______________________________

Please explain any medical problems that your child has: ______________________________

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Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment. ❑ Cash ❑ Personal Check ❑ Credit Card ❑ VISA ❑ MasterCard ❑ Care Credit ❑ Discover

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Lakeview Dentistry of Charlevoix, P.C. of any changes in my child's medical status. **I also authorize the dental staff to perform routine diagnostic and preventive services including, but not limited to, examination, simple cleaning, x-rays, fluoride treatment and oral hygiene instruction.** I also authorize Lakeview Dentistry of Charlevoix, P.C. to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to Lakeview Dentistry of Charlevoix, P.C. any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

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Signature of Parent or Guardian Date

Dentist's Review: ______________________________

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Signature Date