CHARLES P. BRENNER, D.D.S., P.A.
Pediatric Dentist

145 East Carroll Street Salisbury, Maryland 21801
410-749-0133 1-800-962-2016 Fax: 410-749-0284

Dr Charles P Brenner Website: www.dentistryforyoungpeople.com Email: info@dentistryforyoungpeople.com

Name of Patient_____ _____ **Sex** _____
Last Name First Middle Nickname

Address: _____ **Date of Birth** _____

_____ **Zip**_____ **Home Phone**_____

Father (or Guardian) Name_____ **Date of Birth**_____

Address _____ **Social Security #**_____
(If different from child's) (required if using insurance)

_____ **Zip**_____ **Home Phone**_____ **Driver's License #:**_____

Employer_____ **Father Cell Phone:**_____

Employer's Address_____ **Work Phone**_____ **Ext**_____

_____ **Zip**_____ **Occupation:**_____

Mother (or Guardian) Name_____ **Date of Birth**_____

Address _____ **Social Security #**_____
(If different from father's/child's) (required if using insurance)

_____ **Zip**_____ **Home Phone**_____ **Driver's License #:**_____

Employer_____ **Mother Cell Phone:**_____

Employer's Address_____ **Work Phone**_____ **Ext**_____

_____ **Zip**_____ **Occupation:**_____

Have any of your children been seen in this office? _____ **Their name(s)?**_____

Be part of our e-mailing list, please provide us with your email address:_____**@**_____
And be sure to Like our page on Facebook Find us at Dr Charles P Brenner

Emergency contact (other than Parent/Guardian)_____ **Relationship**_____

Address:_____ **Phone Number**_____

How did you hear about our office?_____

DENTAL INSURANCE
Insurance Company (or Medicaid & Medicaid #)_____

Address of Insurance Company_____ **Zip**_____

Insurance Phone_____ **Group #**_____ **Insured's Name**_____

Insured's ID/SS#_____ **Insured's Date of Birth** _____ **Relation to patient**_____

The policy of this office is that the parent/legal guardian who signs for/requests treatment for the child(ren) is ultimately responsible for all fees and services rendered. Any payments and insurance copayments are expected to be paid in full on the date of service, unless other arrangements are made in advance. Any remaining balances after insurance payments are also that of the insured/guarantor. By signing, I give my permission to have any insurance reimbursements be paid directly to Charles P. Brenner, D.D.S., P.A., unless other arrangements are indicated. We reserve the right to charge for or limit appointment availability for any appointment missed without giving adequate advance notice. A 1 ½ % service charge/billing fee (min. $2.00) will be added to all accounts after 30 days as well as a collection fee of 40% of the account balance for any account that is sent to an outside collection agency. We do not accept payment by check for any delinquent account.

_____ _____ _____
Relationship to patient **Signature of parent/guardian requesting care** **Date**

*******PLEASE SEE OTHER SIDE********

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HEALTH INFORMATION

Patient's Name_____ **Date of Birth**_____

Last Dental Exam (including school-based programs)_____ **If so, Where?** _____

What treatment was done?_____

Patient's Physician_____ **Physician's Phone**_____

Physician's Address_____**Zip**_____

Last Medical Examination_____

Has your child ever been hospitalized?_____ **If so, When and For what reason**_____

_____ _____

Is your child on any medication? _____**If so, What and For what reason**_____

_____

Does your child have any allergies to medications? _____**If so, what**_____

Any allergies/reactions to dental anesthetics?_____**If so, what?**_____

Any other food or environmental allergies? _____**If so, what**_____

*****CIRCLE YES OR NO *** IF YOUR CHILD HAS/HAD A HISTORY OF OR ANY DIFFICULTY WITH ANY OF THE FOLLOWING:**

Anemia.....Yes – No
Asthma.....Yes -- No
Birth Defect.....Yes -- No
Bleeding Disorders.....Yes -- No
Blood Transfusion.....Yes -- No
Cerebral Palsy.....Yes -- No
Convulsions.....Yes -- No
Diabetes.....Yes -- No
Depression……. Yes -- No
Epilepsy.....Yes -- No
Fainting.....Yes -- No
Hearing.....Yes -- No
Heart Trouble/Murmur.....Yes -- No
Hepatitis.....Yes -- No
HIV/AIDS.....Yes -- No
Immune System.....Yes -- No
Kidney Disease.....Yes -- No
Artificial Prosthesis…… Yes -- No
Liver Disease.....Yes -- No
Muscle or Bone Disease…...Yes – No
Rheumatic Fever.....Yes – No
Scarlet Fever.....Yes – No
Sight.....Yes – No
Speech Problems.....Yes – No
Thyroid.....Yes – No
Tuberculosis.....Yes – No
Nervous Disorders……..Yes – No

Any other social, developmental or health diagnosis or concerns not listed above that you feel we should be aware of? (i.e. autism, sensory issues, abuse, etc.)_____

_____

Does or Did your child have any of the following habits?
Finger or Thumb sucking **Pacifier Habit** **Was or Is your child breast fed or bottle fed?**

Is there any additional information that may help us in caring for your child or any specific concerns that you have regarding your child's dental health?_____

_____

I agree that the information provided is correct to the best of my knowledge and I give my permission for treatment in this office. We reserve the right to charge for or limit appointment availability for any appointment missed without adequate advance notice given. A billing fee will be added to all accounts after 30 days as well as 40% collection fee for any account sent to an outside collection agency, there may be additional costs for any court service and filing fees that are incurred for the account. We do not accept payment by check for any delinquent account.

_____ _____
Date Signature of Parent or Guardian

_____

_____ _____
Date Charles P. Brenner, D.D.S.