WILLIAM J. JONES, D.D.S.
PHILLIP W.R. JONES, D.D.S.

1 South Main St.
Villa Grove, IL 61956
Phone (217) 832-7011/Fax (217) 832-7011

Today's Date: ____ / ____ / ____

ABOUT YOUR CHILD

Patient Name (First, Middle, Last): _____ Preferred Name: _____ □ Boy □ Girl

Child's Date of Birth: ____ / ____ / ____ Age: _____ School: _____ Grade: ____ SS #: _____

Home #: (____) _____ Parent's Cell #: (____) _____ {Ok to text? □ Yes □ No}

Parent's E-mail address: _____ {Ok to e-mail? □ Yes □ No} Referred By: _____

Child's Address: _____ City_____ State_____ Zip_____

INSURANCE INFORMATION Does either policy cover orthodontics? □ Yes □ No

Primary Dental Insurance

Company Name/Address: _____ Phone #: (_____) _____

Insured's Name: _____ Relation: _____ Insured's ID/SS#: _____

Insured's Date of Birth: ____ / ____ / ____ Insured's Employer/Address: _____

Secondary Dental Insurance

Company Name/Address: _____ Phone #: (_____) _____

Insured's Name: _____ Relation: _____ Insured's ID/SS#: _____

Insured's Date of Birth: ____ / ____ / ____ Insured's Employer/Address: _____

CHILD'S FAMILY INFORMATION

Who is accompanying this child today? Name: _____ Relation to Child: _____

Do you have Legal Custody of this Child? □ Yes □ No --- How many Brothers/Sisters? ____ Age(s): ____ ____ ____ ____ ____

Mother's Name: _____ Address: _____ City_____ State_____ Zip_____

Home #: (_____) _____ Work #: (_____) _____ Other Contact #: (_____) _____

Social Security #: _____ Date of Birth: ____ / ____ / ____ Driver's License #: _____

Employer/Employer's Address: _____ How Long? _____

Father's Name: _____ Address: _____ City_____ State_____ Zip_____

Home #: (_____) _____ Work #: (_____) _____ Other Contact #: (_____) _____

Social Security #: _____ Date of Birth: ____ / ____ / ____ Driver's License #: _____

Employer/Employer's Address: _____ How Long? _____

-- PLEASE CONTINUE ON BACK --

CHILD'S DENTAL INFORMATION

Reason for today's visit: □ Exam □ Emergency □ Consultation --- Is the child in pain? □ Yes □ No

Indicate any of the following problems: □ Discomfort, clicking or popping in jaw □ Lost/Broken Filling(s) □ Stained Teeth
□ Locking Jaw □ Teeth Grinding □ Red, swollen or bleeding gums □ Ringing in Ears □ Bad breath
□ Loose Tooth □ Broken/Chipped Tooth □ Sensitive tooth, teeth or gums □ Blisters/Sores in or around the mouth
□ Other(s): _____

Does the child require pre-medication? □ Yes □ No □ Don't know Times a day child brushes? _ __ Times a week child flosses? ___
Previous Dentist/Address: _____ Phone #: (_____) _____
Last Dental Exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____ Is the Child's water fluoridated? □ Yes □ No
How would you rate the child's smile? **Worst** 1 2 3 4 5 6 7 8 9 10 **Best**

CHILD'S MEDICAL HISTORY

Is your child taking any of the following medications? □ Pain Killer (including Asprin) □ Ritalin □ Stimulants □ Blood Thinners
□ Tranquilizers □ Insulin □ Muscle relaxers □ Others: _____

Child's Physician (Doctor's Name and/or Clinic Name): _____ Phone #: (_____) _____
Address: _____ Last Medical Exam: ____ / ____ / ____

Does your child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmurs	**Y N** Tonsilitis	**Y N** Rheumatic Fever	**Y N** Cerebral Palsy
Y N Respiratory Problems	**Y N** Hepatitis	**Y N** Artificial Heart Valves	**Y N** Athma/DifficultyBreathing
Y N Artificial Bones/Joints/Implants	**Y N** Congenital Heart Defect	**Y N** Blood Transfusion(s)	**Y N** Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC	**Y N** Hearing Problems
Y N Diabetes/Hypoglycemia	**Y N** Tuberculosis TB	**Y N** Cancer/Tumors	**Y N** Hemophilia
Y N Psychiatric Problems	**Y N** Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy	**Y N** Birth Defects

Please list any other medical condition(s) or surgeries your child has or ever had: _____

Is child allergic to: □ Latex □ Penicillin/Amoxicillin □ Tetracycline □ Dental Anesthetics(Novacaine) □ Asprin □ Others: _____
Please rate your child's general health: **Worst** 1 2 3 4 5 6 7 8 9 10 **Best** Child's Blood Type: _____
Does your child wear contact lenses? □ Yes □ No -- Has this child ever taken the drug Ritalin? □ No □ Yes/How long?_____
Does child do any of the following? □ Thumb/Finger Sucking □ Tongue Thrusting/Sucking □ Heavy Snoring □ Lip Sucking/Biting
Does your child use tobacco? □ No □ Yes/How used? _____How much? _____ How long? _____
For girls: Is your child taking Birth Control pills? □ Yes □ No How many children has she had?_____
Is she pregnant? □ No □ Yes/How far along?_____ Is she nursing? □ Yes □ No

ACCOUNT INFORMATION

Name of person ultimately responsible for the account: _____ Relation to child: _____
Billing Address: _____ Phone: (_____) _____
Payment Method: □ Cash □ Check □ Credit Card _____ Exp: ____ / ____
Social Security #: _____ Date of Birth: ____ / ____ / ____ Driver's License #: _____

_____ (initials) - I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

- We request that patients pay co-pays and deductibles at the time of service. Benefits paid by insurance companies vary greatly from carrier to carrier and plan to plan. We do expect the patient to be aware of their benefits and coverage for their particular insurance policy. We would like you to present a current insurance card at every appointment. We will file insurance claims, as well. However, the patient is ultimately responsible for payment expenses incurred in the course of treatment at the time of treatment. For our self pay patients, payment is due at the time of service.
- Unpaid balances will be billed by monthly statement. All unpaid balances that are not awaiting an insurance payment will be assessed a finance charge of 1.5% monthly (18% annually). Failure to resolve payment within 60 days will be subject to collection procedures, and the patient and/or responsible party shall be responsible for collection costs of 50% of the balance due plus attorney fees totaling 33% of balance plus court costs. There is a $25 charge for the following services: returned checks, completion of forms, and letter writing.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I read and understand the WILLIAM J. JONES, D.D.S. & PHILLIP W.R. JONES, D.D.S. Notice of Privacy Practices.

Signature _____ □ Parent/Guardian □ Other: _____ Date ____ / ____ / ____