**SIMPSONVILLE DENTAL ASSOCIATES**
**DEPENDENT QUESTIONNAIRE**

APPOINTMENT POLICY
Appointment times are reserved exclusively for each patient. Please provide 24 hours notice to change or cancel an appointment, otherwise, there will be a charge to your account.

DATE________________________
Child's Name__________________________Name he/she would like to be called______________________
**Date of birth**__________________________
Address__________________________________________________________________________________
City & State________________________________________________________________________________
Zip Code_________________ Home Phone Number_____________________Cell#_____________________
Father's name________________________________Father's DOB__________________________________
Employer___________________________________Occupation__________________________________
Business Address_____________________________________________________________________
Business Phone______________________________Ext.__________________________________________
Mother's name_______________________________Mother's DOB_________________________________
Employer___________________________________Occupation__________________________________
Business Address_____________________________________________________________________
Business Phone______________________________Ext.__________________________________________
Name of person financially responsible for this account___________________________________________
Is this child covered by dental insurance? Father's__________________Mother's_____________________
INSURANCE ID#_________________
Social Security Numbers Father's_______________________Mother's_____________________________
I hereby authorize payment to Simpsonville Dental Associates, PA of the insurance benefits otherwise payable to me_________________________________________ ___________________________
Signed (Insured person) Date
Do mother, father and child live together?____________________If no, explain________________________
Name of child's physician_______________________________________________________________
Is your child taking any medication?__________What?___________________________________________
Does your child have/had any of the following?
Please indicate with a check mark

___ Any heart problems
___ Circulatory problems
___ Problems with blood pressure
___ Asthma
___ Hepatitis
___ Psychiatric care
___ Excessive bleeding
___ Tuberculosis
___ Is there a possibility of your daughter being pregnant?
___ Use of any form of tobacco
___ HIV (AIDS Virus)
___ Cancer
___ Diabetes
___ Allergies_______ _________________________
___ Drug Allergies____________________________
___ Heart murmur
___ Stroke
___ Ulcer

Has child been treated with **Bisphosphonate** drugs?_______________________________________________
Other important medical history_____________________________________________________________
___________________________________________________________________________________________
Has your child ever been diagnosed as hyperactive?_____________________________________________
Name of your child's previous dentist_______________________________________________________

---

Where do you get your water supply? Community system___________Well_________________________
Do you use a water filter?____________ Do you use bottled water?___________________________________
How did you choose our office?_____________________________________________________________
List family members who are patients in our office_________________________________________________
I prefer to pay my portion of any charges with:
___ Cash ___ Check ___ VISA ___ MasterCard ___ Discover ___ American Express

_____________________________________________________________
Signature of responsible party

*For the protection of your child's teeth, we strongly recommend fluoride twice a year. However, some insurance companies cover only once a year.
**Do you approve the application of fluoride twice a year? YES or NO**