Pediatric Dentistry San Ramon

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Child's name: _____Nickname:_____ Sex: (M) (F)

Purpose of visit: _____Concerns:_____Birthdate:_____

Name and age of brothers/sisters: _____Is your child adopted? Y N

Child's Interests: _____Name of Pet(s):_____

Does your child have any special needs? _____ Any phobias? _____

Child's learning: slow average accelerated Child's school: _____

Who may we thank for referring you to us? _____

Health History

Child's Pediatrician: _____Phone number : (_____)_____Last Physical: _____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including Bisphosphonates and over the counter)? Y N If yes, please list:_____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when)_____

Does your child have allergic reaction to: (if yes: please check all that applies)

___Peanuts/Tree nuts	___Soy	___Latex/Rubber	___Pollen/Dust/Environmental	___Anesthetics
___Eggs	___Metals	___Animals	___Berries	___Acrylic
___Milk	___Wheat/Gluten	___Dyes/Coloring	___Others:_____	

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Medications	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever/Heart	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

Other:_____

I have reviewed my child's medical history. Signed _____ Date_____

Dental History

Is this your child's first dental visit? Y N If no, previous dentist: _____ Phone number: (_____)_____

Date of last visit: _____ How was his/her experience? _____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Has your child done any of the following (past or present)?

Please circle: thumb/finger-sucking pacifier nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? _____With adult supervision? Y N How often does your child floss? _____

How may we help to make this visit a positive experience for your child? _____

For families with reverse osmosis filtration or in an unfluoridated area, are you interested in a fluoride supplement? Y N

General Information

Father (full name) _____SSN:_____Birthdate:_____Driver's License #:_____

Mother (full name) _____SSN:_____Birthdate:_____Driver's License #:_____

Parent(s) are: Married____ Divorced____ Single____ Widowed____ Partners____ Child lives with: both parents mother father other

Home Address: _____Home Phone: (_____)_____
Street City Zip

Father's Employer: _____Cellular Phone: (_____)_____

Business Address:_____Work Phone: (_____)_____

Mother's Employer: _____Cellular Phone: (_____)_____

Business Address:_____Work Phone: (_____)_____

E-mail Address:_____ Person financially responsible for child's dental care:_____

Emergency Contact:_____Address:_____Phone: (_____)_____

How would you like us to contact you? Home Work Cell E-mail

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:_____Relationship:_____Date:_____

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company:_____Group Number:_____

Address of Father's Insurance Company:_____

Mother's Insurance Company:_____Group Number_____

Address of Mother's Insurance Company:_____

Financial Agreement

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion the day of dental treatment.
For patients without insurances: payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

SIGNATURE:_____Relationship:_____ 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 of:
___Individual refused to sign ___Communication barriers prohibited obtaining the acknowledgement ___An emergency situation prevented us
___Acknowledgment not returned by parent. HIPAA information given
Medical and Dental History Reviewed Verbally with Parent/Guardian for Patient Named Above: Initial_____Date:_____