

WELCOME

18480 Prospect Road
Saratoga, CA 95070

(P) 408-873-0308
(F) 408-873-0368

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime. All information will remain secure and confidential.



TELL US ABOUT YOUR CHILD

Today's Date:

Child's Name:

(Last) (First) (Middle)

Child's birth date: Child's age:

Nickname: Male Female

School: Grade:

Child's HM#: SS#:

Child's Home address: (Apt / Condo #)

(City) (State) (Zip)



WHO IS ACCOMPANYING THE CHILD TODAY

Relation:

Name:

(Last) (First) (Middle)

Do you have legal custody of this child? Yes No

Is the child adopted? Yes No

Is the child in a foster home? Yes No

Whom may we thank for referring you?

Previous / Present Dentist:

(Please circle)

Last visit date:

Parent's marital status: Single Widowed Remarried

Married Divorced Separated



PARENT'S INFORMATION

Mother Step Mother Guardian

Name:

(Last) (First) (Middle)

Birth date: HM#:

WK#: Cell#:

Employer:

Length of employment: SS#:

Father Step Father Guardian

Name:

(Last) (First) (Middle)

Birth date: HM#:

WK#: Cell#:

Employer:

Length of employment: SS#:



PERSON RESPONSIBLE FOR ACCOUNT

Name:

(Last) (First) (Middle)

Billing address: (Apt / Condo #)

(City) (State) (Zip)

WK#: HM#:

Employer: DL#:

Relationship: SS#:

Who is responsible for making appointments?

Name:

(Last) (First) (Middle)

WK#: HM#: Cell#:



DENTAL INSURANCE

Orthodontic Coverage? Yes No

Insurance Co. name:

Insurance Co. address:

(City) (State) (Zip)

Insurance Co. phone:

Group# (Plan, Local, or Policy#):

Policy owner's name:

Relationship to patient:

Policy owner's birthdate: SS#/ID#:

Policy owner's employer:

Employer's address:

(City) (State) (Zip)

Orthodontic Coverage? Yes No

Insurance Co. name:

Insurance Co. address:

(City) (State) (Zip)

Insurance Co. phone:

Group# (Plan, Local, or Policy#):

Policy owner's name:

Relationship to patient:

Policy owner's birthdate: SS#/ID#:

Policy owner's employer:

Employer's address:

CONTINUED ON BACK



MEDICAL HISTORY

Has the child experienced the following medical problems?

Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N	Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N
AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A / B / C	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Any Hospital Stays	<input type="checkbox"/> Y <input type="checkbox"/> N	Hives	<input type="checkbox"/> Y <input type="checkbox"/> N
Any Operations	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Immunizations Current	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N
Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N	Liver Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N	Measles	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes I / II	<input type="checkbox"/> Y <input type="checkbox"/> N	Mononucleosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Exposed to HIV, but Neg.	<input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Handicaps / Disabilities	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing Impairment	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis (TB)	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N		
Anything you would like to discuss with the Doctor in private?		<input type="checkbox"/> Y <input type="checkbox"/> N	

Please discuss any serious medical problems the child experiences/ed:

Does / did the child have any of the following habits?

Lip Sucking / Biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Nursing Bottle Habits	<input type="checkbox"/> Y <input type="checkbox"/> N
Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N	Thumb / Finger Sucking	<input type="checkbox"/> Y <input type="checkbox"/> N
Chewing on Objects	<input type="checkbox"/> Y <input type="checkbox"/> N	Tongue / Cheek Biting	<input type="checkbox"/> Y <input type="checkbox"/> N
Mouth Breather	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Cleaning / Grinding Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Tongue Thrust	<input type="checkbox"/> Y <input type="checkbox"/> N
Used Pacifier	<input type="checkbox"/> Y <input type="checkbox"/> N	Breast Fed	<input type="checkbox"/> Y <input type="checkbox"/> N

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials:

Date:

Doctor's Comments:

MEDICAL HISTORY UPDATE

1. Date: _____ Signature: _____

Comments: _____



DENTAL HISTORY

What is the primary reason for today's visit?

Has the child experienced problems with previous dental work?

Yes

No

Is the child's water fluoridated?

Yes

No

Is the child taking fluoridated supplements?

Yes

No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)?

Yes

No

Does the child brush his / her teeth daily?

Yes

No

Floss his / her teeth daily?

Yes

No

Child's physician:

Phone:

Date of last visit:

Is the child currently under the care of a physician?

Yes

No

Please describe the child's current physical health:

Good

Fair

Poor

Please list all drugs that the child is currently taking:

Please list all drugs / materials that the child is allergic to:

our office is committed to meeting or exceeding the standards of HIPPA privacy act and infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

(Signature of Parent or Guardian)

(Date)