# WELCOME

18480 Prospect Road
Saratoga, CA 95070

(P) 408-873-0308
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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 | ☐Y☐N | Hemophilia | ☐Y☐N |
| AIDS | ☐Y☐N | Hepatitis A / B / C | ☐Y☐N |
| Anemia | ☐Y☐N | High Blood Pressure | ☐Y☐N |
| Any Hospital Stays | ☐Y☐N | Hives | ☐Y☐N |
| Any Operations | ☐Y☐N | HIV+ | ☐Y☐N |
| Asthma | ☐Y☐N | Immunizations Current | ☐Y☐N |
| Cancer | ☐Y☐N | Kidney Disease | ☐Y☐N |
| Chicken Pox | ☐Y☐N | Liver Problems | ☐Y☐N |
| Congenital Heart Defect | ☐Y☐N | Low Blood Pressure | ☐Y☐N |
| Convulsions | ☐Y☐N | Measles | ☐Y☐N |
| Diabetes I / II | ☐Y☐N | Mononucleosis | ☐Y☐N |
| Epilepsy | ☐Y☐N | Rheumatic Fever | ☐Y☐N |
| Exposed to HIV, but Neg. | ☐Y☐N | Scarlet Fever | ☐Y☐N |
| Handicaps / Disabilities | ☐Y☐N | Skin Rash | ☐Y☐N |
| Hearing Impairment | ☐Y☐N | Tuberculosis (TB) | ☐Y☐N |
| Heart Murmur | ☐Y☐N | | |

Anything you would like to discuss with the Doctor in private? ☐Y☐N

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

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

| | | | |
|---|---|---|---|
| Lip Sucking / Biting | ☐Y☐N | Nursing Bottle Habits | ☐Y☐N |
| Nail Biting | ☐Y☐N | Thumb / Finger Sucking | ☐Y☐N |
| Chewing on Objects | ☐Y☐N | Tongue / Cheek Biting | ☐Y☐N |
| Mouth Breather | ☐Y☐N | Speech Problems | ☐Y☐N |
| Cleaning / Grinding Teeth | ☐Y☐N | Tongue Thrust | ☐Y☐N |
| Used Pacifier | ☐Y☐N | Breast Fed | ☐Y☐N |

## 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 exceedig 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)

## 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:**

**2. Date:** **Signature:**

**Comments:**