PEDIATRIC DENTISTRY OF REDLANDS AND ASSOCIATES

1481 Ford Street, Suite 101
Redlands CA 92373
Phone **909 793 4326** • Fax 909 793 4339
www.**PediatricDentistryofRedlands**.com

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General Dentist
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General Dentist

Patient Info

Today's Date: _____

Child's Name: _____ (Last / First / MI) Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ◯ Male ◯ Female School: _____ Grade: _____

Whom may we thank for referring you? _____

What is the primary reason for today's visit? _____

Is your child adopted? ◯ Yes ◯ No Has any member of your family been or is currently a patient in this office? ◯ Yes ◯ No

If yes, name: _____

Medical History

Child's Physician: _____ Phone: (_____) _____ Date of last visit: _____

Address: _____ (Street / City / State / Zip)

Is your child currently under the care of a physician? ◯ Yes ◯ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ◯ Good ◯ Fair ◯ Poor Are Immunizations Current? ◯ Yes ◯ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ◯ Yes ◯ No

Has your child had / experienced any of the following: (please circle)

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Heart Murmur	Y N Recurrent Headaches
Y N AIDS / HIV+	Y N Congenital Birth Defect	Y N Hemophilia	Y N Frequency
Y N Allergies	Y N Congenital Heart Defect	Y N Hepatitis	Y N Rheumatic Fever
Y N Anemia	Y N Diabetes	Y N High Blood Pressure	Y N Seizures
Y N Any Hospital Stays	Y N Endocrine System Disorders	Y N Hives	Y N Scarlet Fever
Y N Any Operations	Y N Epilepsy	Y N Kidney Problems	Y N Sickle Cell Anemia
Y N Asthma	Y N Frequent Infections	Y N Liver / GI System Problems	Y N Sight Disorders
Y N Autism	Y N Handicaps	Y N Low Blood Pressure	Y N Significant Injuries / What
Y N Blood Dyscrasis	Y N Behavior / Learning	Y N Lupus	Y N Skin Rash
Y N Blood Transfusion/Date	Y N Disabilities	Y N Measles	Y N Tonsilitis
Y N Breathing / Lung Problems	Y N Mentally / Physically Disabled	Y N Mitral Valve Prolapse	Y N Tuberculosis (TB)
Y N Cancer / Tumors	Y N Hearing Impaired	Y N Mononucleosis	

Please discuss any serious medical problems your child experiences, now or in the past: _____

_____

Dental History

Is your child currently in pain? _____ ◯ Yes ◯ No Is this your child's first dental visit? ◯ Yes ◯ No

Has your child experienced problems with previous dental work? ◯ Yes ◯ No If so, explain: _____

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc.? ◯ Yes ◯ No

Does your child take fluoride vitamins or drink fluoridated water? ◯ Yes ◯ No

Has your child been seen by an orthodontist? ◯ Yes ◯ No Who? _____

Does your child brush his / her teeth daily? ◯ Yes ◯ No Does he / she require parental help? ◯ Yes ◯ No

Does your child floss his / her teeth daily? ◯ Yes ◯ No Does he / she require parental help? ◯ Yes ◯ No

Does / did your child have any of the following habits? (please circle)

Y N lip sucking and nail biting	Y N chewing on objects	Y N jaw pain	Y N clenching / grinding teeth
Y N thumb / finger sucking	Y N nursing bottle habits	Y N tongue / cheek biting	Y N used pacifier
Y N tongue thrust	Y N mouth breathing	Y N speech problems	Y N breast fed

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Parents Information

Family's E-Mail: _____ Parent's Marital Status: ◯ Married ◯ Divorced ◯ Single

Parent or Guardian: Home Phone #: (____) _____ Work Phone #: (____) _____ Cell Phone #: (____) _____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Parent or Guardian: Home Phone #: (____) _____ Work Phone #: (____) _____ Cell Phone #: (____) _____

Name: _____ Social Security #: _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Name of parent who resides with the child: _____

Nearest relative: _____ Address: _____ Phone #: (____) _____

Is your child covered by a dental insurance plan? ◯ Yes ◯ No

Insurance Information

Primary Dental Insurance

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local, or Policy#): _____

Insurance Co. Address: _____
PO Box / Street City State

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____ Home Phone #: (____) _____
Zip

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local, or Policy#): _____

Insurance Co. Address: _____
PO Box / Street City State

Insured's Name: _____ Relationship to Patient: _____

Insured's Address (if different from above): _____ Home Phone #: (____) _____
Zip

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____