

1481 Ford Street, Suite 101
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www.PediatricDentistryofRedlands.com

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General Dentist

Patient Info

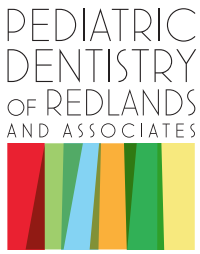
Today's Date: _____
Child's Name: _____ Child's Birthdate: ____/____/____ Child's Age: _____
Last First MI
Nickname: _____ Male Female School: _____ Grade: _____
Whom may we thank for referring you? _____
What is the primary reason for today's visit? _____
Is your child adopted? Yes No Has any member 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 Dyscrasia Y N Behavior / Learning Y N Lupus Y N Skin Rash
Y N Blood Transfusion/Date Y N Disabilities Y N Measles Y N Tonsillitis
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: _____