



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in creating your beautiful smile!

Patient Information

Preferred Name (nickname): _____ Male: _____ Female: _____

Whom May We Thank For Your Referral: _____

Address: _____

City: _____ State: _____ Zip: _____

Last Check-up/Cleaning: ____/____/____ Home Telephone: (____) _____ - _____

Responsible Party Information

Mother/Guardian Name: _____ Date of Birth: ____/____/____

Social Security: _____ - _____ - _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

****Email:** _____

Father/Guardian Name: _____ Date of Birth: ____/____/____

Social Security: _____ - _____ - _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ - _____ Work:(____) _____ - _____ Cell:(____) _____ - _____

Primary Insurance Coverage

Primary Insured Name: _____ Date of Birth: ____/____/____

Relationship to Patient: _____ ID#: _____

Employer: _____ Address: _____

Name of Insurance: _____ Group Number: _____

Address: _____ Telephone: (____) _____ - _____

Secondary Insurance Coverage

Secondary Insured Name: _____ Date of Birth: ____/____/____

Relationship of Patient: _____ ID# _____

Employer: _____ Address: _____

Name of Insurance: _____ Group Number: _____

Address: _____ Telephone: (____) _____ - _____

Health History

Purpose of today's dental examination? _____

•Personal

Name _____ Date of Birth _____ Age _____

Is your child adopted? Yes No If yes, does your child know? Yes No

Physician's Name _____ Telephone _____ - _____ - _____

Family Dentist _____ Name of child's school _____

•Child's Dental History

Has child seen a dentist before? Yes No Where: _____

If yes, approximate date of last visit _____

Unfavorable experiences in a dental or medical office? Yes No

if yes, please explain: _____

How often does your child brush teeth? _____ Do you help? Yes No

How often does your child floss? _____ Do you help? Yes No

•Medical History

Yes No AIDS/HIV

Yes No Cleft Lip/Palate

Yes No Kidney Disease

Yes No Allergies to latex

Yes No Developmental Delay

Yes No Liver Disease

Yes No Anemia

Yes No Diabetes

Yes No Rheumatic Fever

Yes No ADD/ADHD

Yes No Epilepsy

Yes No Sinus Problems

Yes No Bladder Problems

Yes No Heart Problems

Yes No Thyroid Disease

Yes No Cancer

Yes No Hepatitis

Yes No Trauma to mouth/face

Yes No Cerebral Palsy

Yes No Jaundice

Yes No Tuberculosis

Yes No Premature

Yes No Stomach problems

Yes No Blood Disorders

Yes No Hospital stays or operations

Other: _____

-Is your child currently taking any medication? Yes No If yes, list names and purpose _____

-Does your child have any breathing problems? Yes No _____

-Breathes primary through: Nose Mouth _____

-Does your child snore? Yes No _____

-Is your child taking any supplemental fluoride? Tablets Drops Water Vitamins

•Allergic or reactions to any of the following? None

Aspirin Local Anesthetics Sulfa Drugs

Antibiotics Metal Barbiturates Sedatives

Other: _____

•Habits

Child have any of the following habits?

-Thumb or Finger sucking Yes No

-Nail biting Yes No

-Teeth grinding Yes No

-Pacifier use Yes No

-Biting or sucking lip Yes No

-Did your child use a bottle? Yes No

If yes, when did child stop? _____

-Does your child currently use a bottle? Yes No

If yes, how often during the day? _____

•Family Dental History

Mother Father had a lot of decay

Mother Father had orthodontic care

Mother Father have periodontal disease

Mother Father have TMJ problems

Authorization

The information that I have given is correct to the best of my knowledge. I understand that I 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 for my child. I certify that the patient is covered by insurance with _____ . I assign directly to Encinitas Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that responsibility for payment for dental services provided in the office for my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Encinitas Pediatric Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my child's insurance coverage.

Signature: _____ Date: _____