

PATIENT INFORMATION

date _____

patient name _____ nickname _____

birthday _____ age _____ grade _____ sex: ___ male ___ female

names & age of brothers/sisters _____

school: _____ child's learning: slow average accelerated

child's interest _____ name of pets _____

does your child have any special needs? _____ any phobias? _____

whom may we thank for referring you to us? _____

what is the reason for your child's visit? _____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ relationship _____ phone _____

Name _____ relationship _____ phone _____

HEALTH HISTORY

Child's pediatrician: _____ phone number _____ last physical _____

Is your child under a physician's care now? Y N if yes, reason _____

Any hospitalizations or surgery? Y N if yes, when and explain: _____

Is there excessive bleeding when cut? Y N if yes, please explain _____

Is your child currently taking any medications? Y N if yes, please list: _____

Does your child have any allergies ? Y N if yes, please list: _____

Please check if your child has been treated for any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> bleeding/transfusions | <input type="checkbox"/> asthma | <input type="checkbox"/> blood dyscrasias |
| <input type="checkbox"/> liver/GI disease | <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> depression/anxiety | <input type="checkbox"/> mental delays |
| <input type="checkbox"/> speech/hearing | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> premature birth | <input type="checkbox"/> physical delays |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> congenital birth defects | <input type="checkbox"/> emotional | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> cancer/tumors | <input type="checkbox"/> recurrent headaches | <input type="checkbox"/> measles/mumps | <input type="checkbox"/> drug/alcohol abuse |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> fainting | <input type="checkbox"/> TMJ problems | <input type="checkbox"/> other |
| <input type="checkbox"/> down's syndrome | <input type="checkbox"/> eating disorders | <input type="checkbox"/> chemo/radiation therapy | |

please elaborate on any items checked: _____

DENTAL HISTORY

Is this your child's first dental visit? Y N if no, previous dentist? _____ phone _____

Date of last visit _____ how was his/her experience? _____ were any x-rays taken Y N

Child's attitude towards the dentist or dental treatment _____

Has your child had any injuries to teeth, mouth, or head? Y N if yes, please describe _____

Has your child done any of the following (past or present)? Please circle

Thumb/finger sucking pacifier nail biting tongue sucking mouth breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N does your child take fluoride supplements? Y N does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? _____ with adult supervision? Y N How often does he/she floss? Y N

How can we help to make the visit a positive experience for your child? _____

GENERAL INFORMATION

your relationship to the patient? mother father guardian other _____

your general dentist _____ marital status: single married divorced widowed

Father _____ SSN _____ birth date _____ DL# _____

Mother _____ SSN _____ birth date _____ DL# _____

home phone _____ cell phone _____ email _____

home address _____
street city state zip code

do you have legal custody of the child? Y N person financially responsible for child's dental care: _____

how would you like us to contact you? home work cell phone email

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y N

Insurance co.: _____ Policy # _____ Policy owner name _____

Employer: _____ Insurance co. phone # _____ relationship _____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Dr. Chen's professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it responsibility to inform the office of any changes in my child's health status.

SIGNATURE: _____ relationship _____ date _____

FINANCIAL AGREEMENT

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for true dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of \$10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion at the time of dental treatment.

For patients without insurance: Payment in full is expected at the time of dental treatment. When this is not possible, financial arrangements must be made in advance. I realize that failure to keep this account current may result in the dentist unable to provide additional true dental services except for dental emergencies or where there is prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of \$10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

A special time is reserved for your child to allow quality time for your child, *for missed dental treatment appointments* (without at least a 24 hour notice) there will be a \$30 charge.

SIGNATURE _____ relationship _____ date _____