WELCOME

Children's Dentistry of Inland Empire

I. About Your Child

Todays Date: _____/_____/_____ File # _____
Child's Name: _____, _____
Child's Nickname: _____○Boy ○Girl
Child's Birthdate: ____/____/_____Age: _____
Child's Address: _____

_____

Referred by: _____

II. Insurance Information

Primary Dental Insurance
Company Name: _____
Address: _____

_____

Phone Number: _____
Insured's ID #_____
Group # _____
Insured's Name _____
Relation: _____ DOB _____/_____/_____
Insured's Employer _____
Secondary Dental Insurance
Company Name: _____
Address: _____

_____

Phone Number: _____
Insured's ID #_____
Group # _____
Insured's Name _____
Relation: _____ DOB _____/_____/_____
Insured's Employer _____
Does either policy cover Orthodontics treatment? ○ Yes ○ No

III. Child's Family Information

Who is accompanying this child today?

_____ _____
Full Name Relation to child

Do you have Legal Custody of this Child
○Yes ○No

How many Brothers/Sisters? ____ Age: ___ ___

** Mother's Name: _____
○Step Mother ○Guardian
Email address: _____
Home address: _____

_____

○ Check if same as child's
Home phone: _____
Work phone: _____
Mother's SS#: _____
Date of birth: _____
Mother's driver license #: _____
Employer:_____ How Long? _____
Employer's Address: _____

_____

** Father's name: _____
○Step Father ○Guardian
Email address:_____
Home address: _____

_____

○ Check if same as child's
Home phone: _____
Work phone: _____
Mother's SS#:_____
Date of birth:_____
Mother's driver license #: _____
Employer:_____How Long? _____
Employer's Address: _____

_____

IV. Account Information

Person ultimately responsible for account
Name: _____relation to child: _____
Billing address: _____

_____

Social Security #: _____DOB: _____
Driver License #: _____
Work Phone #: _____
Cell Phone #: _____

_____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

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V. Child's Dental Information

Reason for today's visit: ○Exam ○Emergency
○ Ortho Consultation ○ Other _____
Is child in pain? ○ No ○ Yes How Long? _____
Please indicate any of the following problems:
○Discomfort clicking or popping in jaw
○Red, swollen or bleeding gums
○Sensitive tooth, teeth or gums
○Blisters/Sores in or around the mouth
○Lost/Broken filling ○Teeth Grinding
○Broken/Chipping tooth ○ Loose tooth
○Stained teeth ○Lock Jaw ○Bad breath
○Other _____
Does child require pre-medication
○Yes ○No ○ Don't know
Previous Dentist _____
Last Dental Exam _____/_____/_____
Last Dental X-ray _____/_____/_____
Times a day child brushes? ____ Floss? ____
Is the child's water fluoridated? ○ Yes ○ No
How would you rate the child's smile? _____

VI. Child's Medical History

Is Child taking any of the following medications?
○ Pain Killers (including Aspirin) ○Ritalin
○Stimulants ○Blood thinners ○Tranquilizers
○Insulin ○Muscle relaxers ○Others:
_____
Child's Physician: _____
Address: _____
_____
Phone number: _____
Last Medical Exam: _____

Does Child have or ever had any of the following disease, medical conditions or procedures?

Y	**N**	Asthma/Difficulty breathing
Y	**N**	Abnormal bleeding
Y	**N**	Artificial bones/joints/implants
Y	**N**	Artificial heart valves
Y	**N**	Birth defects
Y	**N**	Blood transfusion
Y	**N**	Cancer/Tumors
Y	**N**	Cerebral Palsy
Y	**N**	Chemotherapy
Y	**N**	Cleft lip/Palate
Y	**N**	Congenital heart defect
Y	**N**	Diabetes / hypoglycemia
Y	**N**	Fainting/Seizures/Epilepsy
Y	**N**	Hearing problems
Y	**N**	Heart Murmur
Y	**N**	Hemophilia
Y	**N**	Hepatitis
Y	**N**	High/low blood pressure
Y	**N**	HIV+/AIDS/ARC
Y	**N**	Hyper active / ADD
Y	**N**	Jaw problems TMJ/TMD
Y	**N**	Leukemia / Anemia
Y	**N**	Liver/kidney/Organ problems
Y	**N**	Psychiatric problems
Y	**N**	Respiratory problems
Y	**N**	Rheumatic fever
Y	**N**	Scarlet fever
Y	**N**	Surgeries/Operations
Y	**N**	Tonsillitis
Y	**N**	Tuberculosis TB

Please list any other medical conditions(s) child has or ever had:
_____
Is Child allergic to ○ Latex ○Tetracycline
○ Penicillin/Amoxicillin ○Novocaine ○Aspirin
○Food allergies ○Other(s) _____
_____

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Please rate the child's general heath from 1-10 _____

Does child wear contact lenses ○ Yes ○ No

Has this child ever taken the drug Ritalin ○ No ○Yes/How long? _____

Child's blood type: _____

Does this child do any of the following? ○ Thumb/Finger Sucking ○Tongue Thrusting/Sucking ○Heavy Snoring ○ Mouth Breathing ○ Lip Sucking/Biting

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***We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

****Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

*** I authorize the staff of Children's Dentistry of Inland Empire to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

*** I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Initials

Signature _____

○ Parent or Guardian

○ Other: _____

Date: _____/_____/_____